Canadian Psychiatric Association Journal

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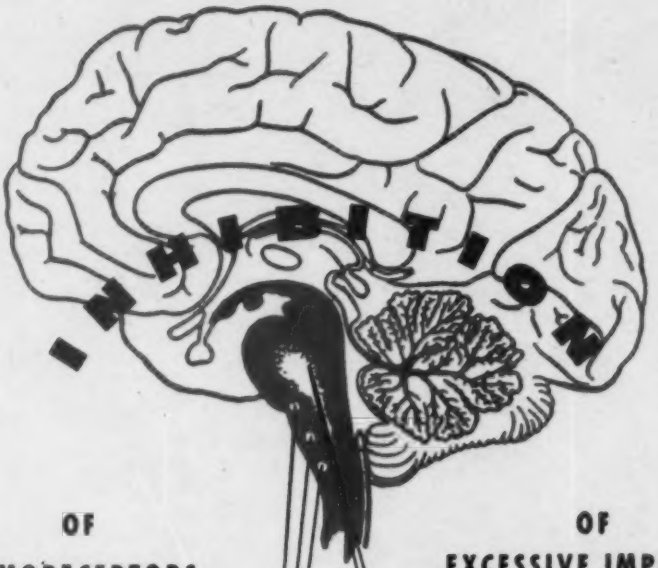
selective effect on subcortical structures...



OF CHEMORECEPTORS IN BRAINSTEM

induced adrenalin central excitatory effect

apomorphine-induced vomiting

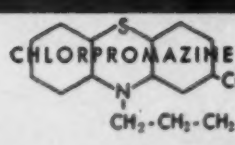
nicotine-induced convulsions

OF EXCESSIVE IMPULSES ARISING IN THE RETICULAR ACTIVATING SUBSTANCE

toning down of arousal reaction

potentiation of other sedatives

LARGACTIL



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2–Ferguson, J.T. (1955) Paper presented at American Society for Pharmacology and Experimental Therapeutics. Sept. 9

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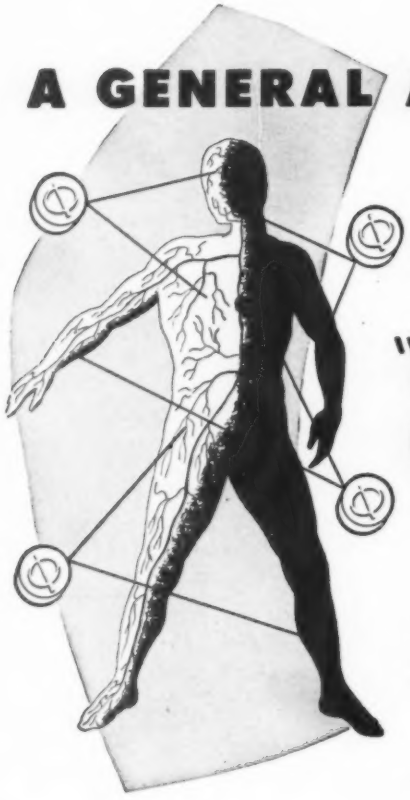

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Canadian Psychiatric Association Journal

Vol. 2 Ottawa, Canada, January 1957 No. 1

AUTISM AND SCHIZOPHRENIA IN A CHILD GUIDANCE CLINIC*

Eva Andrews, M.A. (Toronto); Daniel Cappon, M.B. (London)

Introduction

Raison d'être

This paper is offered as our experience with the clinical manifestations of what we have come to call the "autistic-schizophrenic" spectrum of psychological disorders, encountered in childhood, in a community child Guidance Clinic. It is a continuation of the work done by one of us and reported in the Canadian Medical Association Journal (6), where the inception of our collection of cases and our thinking on them is described.

Our experience extends now over five and a half years and comprises twenty-one cases. We think that data on the prevalence of these conditions is lacking in the literature and therefore that our communicating the local incidence would be useful. We have come to classify more firmly the clinical manifestations described in this paper, and this enabled us to formulate conceptions on aetiology, criteria for prognostication, and for a treatment approach. These we have checked with a follow-up revealing the outcome of these conditions over the five year period. It struck us that although we were dealing with a malignant process, only one out of the twenty-one patients was hospitalized and one other needed institutional care. The rest were coped with in the community and thirteen of this series improved, some remarkably. The implications for a better understanding of the dynamics of this kind of psychological disorder and for its prevention seemed important enough to warrant this final communication of our continued experience.

The Setting

The setting is a clinic serving exclusively an urban community of over 105,000 people, located within a rapidly expanding Canadian metropolis of one and a quarter millions strong. There are some 30,500 children and adolescents in this area. The high proportion of children to adults should be noted. The implication is that the community is young and fertile. This clinic, established as a Federal Mental Health pilot scheme, was linked up early to all the public and high schools, offering them facilities for direct referral. It accepts only the patients domiciled or attending school in this area. For its twofold programme of clinical work and community education, the clinic has gained the increasing recognition of other referring agencies: public health authorities, physicians, social agencies, local religious and political agencies, and finally it has reached the homes of the people. Through its popularity on home and school programmes, where the clinic members have appeared before one in three adults living in this community, two events of significance to this paper have occurred:

1. Younger parents and therefore younger children have been referred to our clinic in greater proportion in more recent years.

2. There have been two shifts in the type of clinical manifestation referred; the first was away from mental deficiency and the other was away from the disturbing child ("Naughty") and towards the more disturbed child ("Morbidly shy").

We think the sample of clinic population is a fairly representative one for the following reasons:

*From Dept. of Psychiatry, Toronto University.

(a) Latterly, no other guidance clinic or hospital outpatient department has accepted psychologically disturbed children from this area but referred them back to us. There are no facilities in this city for child inpatient treatment. There are very few private practitioners in paediatric psychiatry.

(b) We have never advertised our interest in the *autistic* child, nor set up as experts in this or any particular problem. Consequently, there has not been over-selection.

(c) The only attenuating factor is the socio-ethnic texture of the population. It is long (a century) settled Anglo-Saxon, middle and lower classes (13) with a sense of belonging to the "township". There is an industrial perimeter allowing for a new influx of young immigrant workers, especially Italians. In the more prosperous residential area there is an influx from a neighbouring dominantingly Hebrew community. This makes for a "differential" in referral speed. The settled population is slower in the referral of the shy child; the new immigrant population slowest and the aggressive, enlightened, (often over-sophisticated) anxious and successful section of the population is swiftest. However, we have now been long enough established, as we mentioned earlier, to have all sections beginning to refer this kind of case.

Prevalence

With the aforementioned points in mind we offer the following statistics in tabular form:

TABLE I: TOTAL INCIDENCE

	Numbers	% of Total	% of Clinic
Total population	30,500	100.00	–
Clinic population	450	1.5 (A)	100.00
"Autistic" population	21	.06 (B)	5.1

TABLE II: MALE-FEMALE RATIO

	Males	Females	M:F Ratio
Total population	15,500	15,000	103:100
Clinic population	290	160	181:100
Autistic population	19	2	950:100*

* ($p < .001$).

TABLE III (A): AGE-GROUPING

Totals

Age Groups	Total Pop.	Clinical Pop.	Autistic Pop.
1– 4	13,000	44	3
5– 9	7,922	193	12
10–14	6,559	115	5
Over 14	2,958	98	1
Grand total	30,439	450	21

TABLE III (B): PROPORTION OF TOTALS BY AGE GROUPS WITHIN POPULATION

Age Group	Total Pop.	Clinic Pop.	Autistic
1– 4	42.7	9.8	14.3
5– 9	26.0	42.9	57.1
10–14	21.5	25.5	23.8
Over 14	9.7	21.7	4.8
Grand total	100.00	100.00	100.00

Age Group 1–10p < .2.

TABLE III (C): PROPORTION OF TOTALS BY POPULATIONS WITHIN AGE GROUPS

Age Group	Total Pop.	Clinic Pop.	Autistic
1– 4	100	.3	.02
5– 9	100	2.4	.15
10–14	100	1.7	.07
Over 14	100	3.3	.03
Grand total	100	1.5	.06

First it should be pointed out that our proportion 1.5% of disturbed children per children in the community is considerably lower than the often quoted pessimistic Western prevalence of 1 in 25. Necessarily there is always a selection process in operation, whether or not one is aware of it and admits it. In our case, the exclusion from the figures of "brief contacts" which were problems largely non-psychiatric and never studiable enough for diagnosis, (providing an additional 131 cases in 5 years), and the implicit (in that we were a guidance clinic), eventual self-selection away from mental defectives, may alter seriously the validity of ensuing comments on these tables. Yet we found no way of further correcting possible errors. We believe that those interested in the problem treated in this paper have not communicated whether they worked in a "closed community" and whether they were privileged in knowing a great deal about the population. Consequently statistics of this kind are rare, if at all available.

It will be seen that if all the cases in this series are included, "autism" is not a rare disturbance. One may even suggest from the figure of 5.1% "autistic" children in a guidance clinic, that all insiduously developing schizophrenics begin their illness in childhood.

The enormously high incidence of males compared with females is beyond the possibility of chance, even when allowing for the greater prevalence of males brought to our clinic. One must conclude that either the condition is commoner in males or that it is 9½ times better tolerated in females.

If we take the first decade of life, it is significant that 71.4% of patients were diagnosed then and the implication is that there has been a delay of some years in their being brought in for diagnosis. The other implication is, of course, that if autism is not manifest in the first ten years of life it is unlikely to ever become manifest.

Totals

TABLE IV (A): ETHNIC GROUPING

	Total Pop.	Clinic	Autistic
Anglo-Saxon	75,000	336	17
Hebrew	10,000	75	3
"Other"	15,000	39	1
Grand total	100,000	450	21

TABLE IV (B): PROPORTIONS BY ETHNIC GROUPING WITHIN POPULATION

	Total Pop.	Clinic	Autistic
Anglo-Saxon	75	74.7	80.9
Hebrew	10	16.7	14.3
"Other"	15	8.7	4.8
Grand total	100	100	100

TABLE IV (C): PROPORTIONS BY POPULATIONS WITHIN ETHNIC GROUPS

	Total	Clinic	Autistic
Anglo-Saxon	100	.44	.02
Hebrew	100	.75	.03
"Other"	100	.26	.006
Grand total	100	.45 A	.021 B

LEGEND

Total population = Community
Clinic population = Disturbed children seen in Clinic
Autistic population = Series of cases discussed in this paper
X = Significance $p.< .001$ TABLE II and $p.< .2$, TABLE III

A & B TABLE I compared in TABLE IV

No definite suggestion can be made on the distribution of ethnic groupings except that the Hebrew group seems to show a higher proportion especially if analyzed from within ethnic groupings. (Table IV C) This is not consistent with a lack of prevalence of schizophrenics in that ethnic group and is much better explained by the suggestion already made in this paper: that this section of the community was more alert and anxious about emotional problems in their children. But further, it may also be that the group does have a higher incidence of "autism", which "protects" against a development of an active psychotic breakdown. Of course, if this is so and if all insidious and slowly developing schizophrenics begin within a childhood autistic spectrum, then the

question is begged: what within autism "protects" one child (say of the Hebrew group) yet does not protect another?

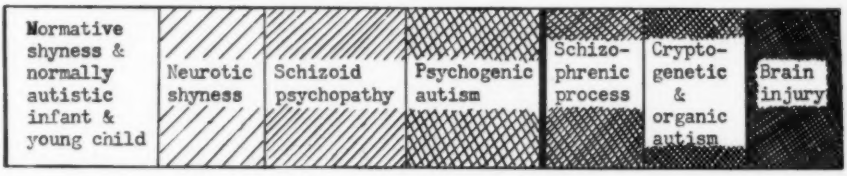
We certainly do not know.

Diagnosis

We endeavoured by systematic, standardized clinical methods (see Appendix) to satisfy ourselves fully regarding the clinical status of the child whom we then placed in a locus on the progressive series ("spectrum") depicted in the following diagram.

DIAGRAM 1

The "autistic spectrum"



This spectrum, arranged as in the initial paper (6), ranged from a normative reaction, to an abnormal one, from a reversible reaction to a definite defect, from minimum psychopathogenesis through maximal, (to the bar) and then to diminishing psychopathogenesis to maximal somatogenesis; from best to worst prognosis.

The dark band on the spectrum represents that "no man's land" of borderline cases. Age was of obvious general importance and specifically we arbitrarily refrained from a firm diagnosis of psychopathy before the age of 8, but would note tendencies toward developing such a total involvement of personality.

Case excerpts exemplifying each of the diagnostic categories in the series are as follows:

I. *Neurotic Shyness*

Case 19.

L.H. – A boy, age 5.4, presented with hostile, disobedient, negativistic behaviour fluctuating with withdrawal, aloofness and preference for playing alone. His interpersonal relations were poor. He was rude, hostile and rebellious with his parents and authority, jealous of his sister and did not play well with others. He refused to enter group activities. He appeared to lack social inhibition but could form rapport and relate to a whole person. Felt rejected and was fearful of society. His relation to objects was adequate and not disturbed but there was some repetitive play and a fascination for organs and elimination. He revealed a body self-consciousness, a sense of inadequacy, guilt regarding masturbation, and fear of castration but he was identified with the male figure. There was distortion in the concept of people's bodies, numerous fears and paranoid trends. His mood fluctuated – mostly in response to his inner life. He was not affectionate – but aloof and withdrawn. He had ability to adapt, however, and had personality assets and strengths. His perceptions were clear. He was indifferent to injuries and punishment but sensitive to criticism and rejection.

In his general psychomotor behaviour he showed manual dexterity. His behaviour fluctuated between out-going and withdrawn and his actions were often unpredictable. He sometimes behaved rigidly, played repetitively and showed obsessive compulsive trends.

Speech was delayed until he was 3 years old but he talked well when referred – enunciated clearly and spoke abruptly.

Onset of this boy's behaviour was during early childhood. At age 2½ he was contrary and disobedient and at 3½ he said "odd" things and cried at nothing. His mother could

not seem to "get through to him". Speech was delayed and there was retarded emotional development. He was healthy physically and his I.Q. was 94 when tested. The family relations and history may have influenced and resulted in this boy's reaction. His mother was immature and markedly obsessive, but anxious for help. She rejected boys generally and this one particularly. The father was away from home a great deal and this boy's behaviour irritated him when he was at home. The home was overcrowded.

Case 7.

N.R. – A boy, age 13, who was tense, fearful and had numerous nervous tics. He day-dreamed frequently, staring into space. He was reticent and reserved about himself and tried to repress all of his feelings. He was fairly easy to get along with – polite and complying with authority – yet with underlying hostility. He got on well with others his own age but did not have any special friends.

He was normal in intelligence (I.Q. 109) but looked poorly fed and in poor physical health.

There was no hereditary loading but the mother appeared dull and was careless and indifferent with her children. The father was ill and treated the children inconsistently – thrashing them if he was annoyed with them.

II. *Schizoid Psychopathy*

Case 10.

R.H. – A boy, age 8½, presented with extreme shyness and a severe secondary stutter. He showed repressed hostility towards his adoptive parents and sister but was very good and obedient with adults in authority. He related slowly to people and would not participate in play with his own age group. He had little feeling of individuality and was repressed in his expression of feelings and in his activities. He had a passive, repressed, unhappy attitude, was extremely shy and self-conscious (about his speech and adoption), and was very cautious in his behaviour. He was slow learning to walk. He didn't walk until 16 months of age. His movements were awkward and there was confusion in laterality. He had a severe stammer, with many body and facial contortions, but he could sing without stuttering.

He was always shy and fearful since boyhood and had always stammered since onset of talking, although this became more severe in the last 2 years. He was normal physically and his I.Q. was 103.

His family history was not known, except that he was an illegitimate child whose father was married and had 3 children of his own.

His adoptive parents were rather cold and defensive and unwilling to see their part in this boy's severe stammer, believing it was "inherited".

Case 9 Developing Schizoid Psychopathy.

B.P. – A boy, age 7, presented with enuresis, nervous tics, and many fears, e.g. of floods, being drowned or lost and of atom bombs etc. He did not make friends and seemed unable to do so. He made no effort to play with and was jealous of other children. He was resistant to authority and tried to get around rules and limits. He was neat and overly clean in his play and in relation to objects in his environment. He was visibly upset at any change or new experiences and felt more secure in familiar situations. He worried unduly about all kinds of things – constantly expressing the feeling of not being safe.

This boy was adopted by his maternal aunt. He was the illegitimate child of a defective mother, born prematurely (11 weeks in an incubator) and by Caesarian section. He was superior in intelligence (I.Q. 125) and normal physically.

His adoptive parents were fond of this child – although the father tended to be aloof, and anxious to help him.

III. *Psychogenic autism*

Case 12.

A.G. – A boy, age 6.10, presented with aggressive, disobedient, contrary, negativistic behaviour. He was very hostile and domineering in his inter-personal relations with his parents, sibs, peers and authority. He did not make friends and could not get along with other children because of his inability to conform to a group, his temper, and his paranoid feelings. He seemed unable to recognize restrictions no matter what the punishment. He had mechanical ability but his co-ordination was poor when he was disturbed and he became wild, irrational, and destructive with toys and furniture. He was possessive about his own things, neat and clean in his personal habits, and compulsive in his activities. He became

upset if anything in his environment (sameness) was disturbed and irritable when frustrated. He looked unhappy, was aloof and markedly paranoid in mood or affect. His thoughts were distorted by his paranoid feelings and also influenced his behaviour.

This boy was deprived emotionally from early infancy. He was in 6 different foster homes during his first seventeen months. His severe temper was noticed when he was 15 months old and at the age of 2 he was extremely jealous, antagonistic, and negativistic. He became steadily worse as he grew older and saw other foster children going and coming from his present home, and his foster sister was born.

Physically he is small, pale and thin. There is right amblyopia and nystagmus. He had an operation and wore glasses. His E.E.G. was normal and his I.Q. was 100.

He was an illegitimate child whose mother was intellectually dull. The foster mother was strict and irritable and found this boy difficult to manage. The foster father was more easy going but suddenly lost patience with the children. He was didactic.

IV. *Schizophrenic Process*

Case 18.

D.L. – A boy aged 13½, presented with clumsy, odd behaviour, confusion in relation to his experiences, garbled and incoherent speech when nervous, and frequent day dreaming. Interpersonal relations were unsatisfactory and his hostility to his father and sibs seemed out of proportion to the external situation. He appeared lonely and unhappy – had never made friends of his own or been accepted by his own age group. He continually got into minor scraps where he seemed to be bullying smaller children or where smaller children were teasing or provoking him. He overreacted because of his lack of companions. He was inadequate in conforming to rules and authority and there was repressed hostility. He over-reacted to acceptance and praise and manifested paranoid feelings. His relation to objects was immature and obsessive. He was able to see wholes fairly accurately; revealed a diffuse global level of perception but had some capacity to differentiate. He was dissatisfied with his own body image and had difficulty accepting himself at all. Was preoccupied with building up his own physique and strength and showed fear of bodily harm. He was over-anxious for affection and attention, over-reacted when praised and was very sensitive – got hurt easily if criticized. He was anxious and had a number of fears and these, with his hostility, were over-controlled in outward expression. Cognition was quite good but he was overly sensitive to stimuli. He indulged in considerable unrealistic day-dreaming and was preoccupied with his turbulent feelings and conflicting needs, as well as with phantasies of power. His thoughts were easily confused and showed paranoid trends. He showed ego distortions and thought disorder of a schizophrenic type. His general psychomotor behaviour was clumsy and odd – but he did have mechanical ability.

He was restless and fidgety and had many facial mannerisms and tics. His speech was hesitant and often garbled and incoherent. There was autochthonous activity when he was alone.

This boy's oddity and withdrawal began to show when he was in kindergarten (age 5). There was no great organic impairment – only the possibility of undetected polio at the age of 6. He was big and clumsy in movements, but otherwise normal physically. His I.Q. was 95.

There was no obvious psychogenic stress and no hereditary factors to account for his reaction. The family was closely knit and had fairly warm relationships. However, the father tended to be obsessive and cold – the mother much more warm and understanding.

Case 17.

J.P. – A boy, age 5.7, presented with poor fluctuating indistinct speech, varied in quality, pitch and loudness. His behaviour was bizarre, and unpredictable and his span of attention was extremely short. He resisted attempts to be taught – particularly by his mother to whom he had ambivalent feelings. He was unable to establish relationships with people but he did try, even though painful to him. He was hostile and fearful with his family and did not get on with other children who rejected and feared him. He withdrew from group activities, seemed frightened and afraid to assert himself. He had strong, spurious, clinging but non-specific attachments to adults. Relations with authority were disturbed – he did not fit into kindergarten, nor conform to school rules. His ego was very weak and there was great disturbance and distortion in his body image. Ego boundaries were fluid. He lacked clear concepts as to his own body limits and had delusions of volitional omnipotence – with use of "magic". He was narcissistically arrested and had painful insight of his being different. His relation with objects revealed concretism. He questioned reality of

objects and toys – could see wholes and differentiate but showed disturbance in recognizing patterns. His behaviour was bizarre, repetitive in acts, mannerisms and rituals. He was hyperactive, lacked concentration and had a poor attention span. He was clumsy manipulating things. His muscle and hand coordination was poor. His speech was often fluctuating and gibberish – not used only for communication. He talked to himself constantly – repeated or condensed words and invented "portmanteau" words of his own. There was marked perseveration in speech as well as in behaviour and play and the condensation of words, and imaginary friends had become an obsession with him. There was a definite need for sameness. His mood was one of extreme anxiety – disorganizing to him and arising from within. He had difficulty discriminating the real from the phantasy world and there was distortion of perception. Thinking was dereistic and magical. Stereotypy. There were many fears – as well as preoccupation with thoughts of excreta and eliminative functions.

Onset of this disturbance was at infancy. He cried and whined incessantly, spoke in a queer "unnatural" voice and had poor motor coordination since the beginning of locomotor behaviour.

There was no sign of organic damage, but this boy was hypochondriacal and had an alimentary canal disturbance. He was short-sighted, otherwise normal physically. He fluctuated in intellectual functioning because of his disturbance. I.Q. scores varied from borderline to normal level.

The family history showed decided loading – especially with psychosomatic symptoms with the mother, neurosis with the father and high intellectual aspirations on both sides of the family. The family situation was classically autistic – the major stress being the relationship between the mother and the boy. She rejected the child – was extremely sensitive and anxious with guilt and shame feelings towards him. The father was less anxious and protective of him.

V. *Cryptogenic Autism*

Case 21.

K.E. – A boy age 4.3, presented with almost a total lack of speech and some enuresis. Interpersonal relations were somewhat disturbed. He made rapport with parents but showed a preference for female persons to male – both at home and in the community. Showed fear and withdrawal with strangers. He used to be very obedient with authority but became negativistic when referred. He had street sense and could join a group of children his own age. Children did not reject him. He related to a person's face more than to the rest of the body. His relation to objects was good but obsessive and repetitive. He was agile and interested in mechanical objects. There was a marked need for sameness, e.g. compulsive tidiness with objects around him. He was adept with puzzles and block building. In his relation to himself, he refused to say "I" and spoke of himself in the third person. There was considerable hostile release in his mood and hearty laughter at this release. The most incongruous action on his part was the sudden, automatic and unrelated crying – stimulated usually by a sudden introduction of strangeness or a stranger. There was some latency to his crying reaction and he could be distracted from it but eventually would come back to it. He revealed many fears and was extremely cautious. Physical pain was ill-tolerated and mental stress was not tolerated at all. He reacted with withdrawal. Conation was immature but he could easily comprehend how things worked.

His general psychomotor behaviour was stereotyped and exact. His coordination was good and he was not hyperinetic.

There was a lack of syntax and immaturity in his speech. There was obvious negativism in his lack of adequate speech. He used condensation of symbolism and onomatopeic displacement. There was idioglossia and some echolalia. He had good verbal understanding. His main disability was functional expression of thoughts and wishes but he could make his wishes understood by those around him.

Onset of this disorder was dated when this boy was 2-3 years of age and was not talking. His vocal activity was restricted because the father slept during the day. There was no physical reason for his defect and the reaction seemed much in excess of the stress of his life.

There was no obvious psychopathic loading in the family history but when studied more minutely – there emerged what made for the eventual blend toward schizoid trend and autism (in the mother's family). The mother was very tense and anxious – did not want a boy but kept her feelings rigidly controlled. She tried to get her children to control their feelings (suppress hostile feelings) and got upset if unsuccessful and the boy was rowdy and noisy. The father was high strung but fond of his family. The home atmosphere was tense. Both parents were anxious for help.

Cryptogenic Autism (with organic and hereditary factors)

Case 20.

S.M. – A girl, age 4.8, presented with little or no speech, fluctuating and bizarre behaviour, lack of habit training, retardation and deterioration. Her interpersonal relations were extremely poor. Communication with others was at an infantile level and then only with those familiar to her, e.g. parents, adults she had seen frequently. With people unfamiliar to her – she shut them out of her awareness but occasionally expressed fear. She was jealous and hostile to her younger sister and was frightened of and hostile towards other children. She was always aware of other children – always angry with them. Her relation to objects was better than to people or herself – but even then – only with a limited number and in an infantile way. She could perceive objects and people and not fall all over them and she was not upset if objects in her surroundings were moved. She was aware of pain, being physically hurt, but there was no reaction to it. Her mood was one of cold withdrawal a large part of the time but fluctuated for no reason. She laughed inappropriately. Temper, anger and irritability were shown as well, e.g. to noise, cars moving towards her, objects falling; new situations or people. She revealed selective inattention in her cognition and her reactions to stimuli were kinaesthetic, oral and auditory, e.g. pacing and humming. Her conation unknown but probably chaotic. She seemed infantile and retarded. Little compulsive behaviour was observed. There was not pattern to her pacing and she was not disturbed by changes in her surroundings. Her general psychomotor behaviour fluctuated between hyperkinetic pacing, running or skipping – to withdrawn passive standing in a corner. There was little purposive behaviour. Motor skills seemed to be deteriorating and she was not habit-trained. There was little or no speech. She had lost much of what she had at an earlier age. She mouthed words and babbled like an infant. She had always been musicogenic.

Onset of this disturbance was in infancy when she was exceptionally quiet and did not notice people. Her motor coordination and speech deteriorated as she grew older. There was a possibility of a brain lesion (frontal lobe) and other biological processes involved. She had two bad falls (hitting her head) before the age of one year. Intelligence testing was difficult – if not impossible, but she showed retardation to the one year level, with motor skills at the 2 year level of development.

The family history showed hereditary loading. The father was epileptic and rigid, the mother cold and rejecting.

VI. *Brain Injury*

Case 15.

G.H. – A boy, age 6, with marked obsession for clothes hangers and sticks, uncontrolled destructive behaviour. He was unmanageable, excitable, high strung and had a violent temper. His interpersonal relations were disturbed. He was hostile towards younger children and didn't play well with his peers. He behaved in an uncontrolled way with adults. He was hostile to people in general. Punishment had no effect. His relation to objects was better than with people. He played obsessively and compulsively however – e.g. collected sticks and clothes hangers and strung them in a row. There was a marked need for sameness. His perception of himself was distorted, as were all perceptions. Perceptions were hostile and obsessional. He would pursue an idea to the point of danger to himself and yet be unaware or unconcerned about this threat. He could not be diverted from an idea and was stubborn to the point of hurting himself. Though he was unaware of pain, mental frustration was ill-tolerated and he became angry and destructive. His thoughts were bizarre and showed irrelevancy and condensation. His behaviour was uncontrolled, disturbing and restless. He was agile but revealed bizarre actions at times – some resembling whirling. His development was delayed with the exception of habit training. His speech was immature, thick, and repetitive. Occasionally he said odd phrases and ununderstandable words but he was exposed to two languages at home. Stereotypy was marked.

Onset of this disturbance was at birth but it had increased when he entered school. He was cyanosed at birth and at 3½ years both sides of his skull were operated on. Convulsions were controlled with barbiturates. He showed poor attention and concentration. His intelligence was borderline (I.Q. 73).

The home atmosphere was poor – with an unhappy marital relationship between the parents. The father was defensive and projected the blame for this boy's condition on to doctors and schools. The mother broke treatment.

Comments on the evaluation of criteria for placing a patient on the spectrum

Since the child's mental processes are dynamic, we sought to weigh the "dynamic factors" against the measurable or at least describable reactions making up the clinical picture. Inevitably our criteria are of two orders:

A. Interpretive (subjective)

B. Descriptive (objective)

Interpretations:

These are in response to our questions. (1, 2 and 5)

1. If psychogenic factors alone, accounted for the resulting "autism", we classified in the "frequency" of maximal psychopathology from neurosis to psychotic process.

2. If through continued observation and extension of guidance into a treatment process we judged that amelioration of strain led to or would lead to a palpably beneficial effect on the reaction, we classified towards the left of the spectrum.

Later, we checked our impressions with a follow up.

3. If the extent of disarticulation was large and depth profound, where psychogenic factors though potently present seemed nonetheless insufficient and capable of relief, we tended to classify to the right.

4. Finally, though the age of onset should be a verifiable descriptive fact, we may place it here between the fact and interpretation because memory and parental protective dynamics are such that answers are falsifiable, despite our great care in checking them.

However, the earlier the conditions appeared the more our tendency to classify to the right.

Description

Firstly, known brain injury, in the broad sense of the term, and its demonstable effects, positive signs in an examination for frontal, parietal or temporal lobe injury and a history of severe autonomic system disturbance anoxia neonatorum etc., made for weighting to the right end of the spectrum.

Next, each observation made (inclusive of tests) on our schema for clinical examination, was weighted and resulted in clustering somewhere on the spectrum.

Thus, quantitatively, the less outwardly distributed the libido, and the more investment into inanimate objects, and the more distortion of body image, and the more disturbance in speech, and the more change in psychomotor system, and the greater alteration of perception of pain and disproportion between perception and reaction to psychic versus physical pain, the more mood incongruity, the greater changes in conation and need for sameness and compulsiveness, the more shift to the right of the spectrum. Qualitatively, we sought to define broad impressions and finally we sought to integrate them dynamically within the life experience of the child.

We called (1) the very young child normally autistic if his total self-preoccupation was consistent with age – and if he was actively shifting to extraversion and ever wider distribution of libido. If there was some minor difficulty in doing so, with a sense of shyness and exaggerated self consciousness and some sensitivity and no more – if the discomfort was not great and socialization occurring, we called it "normative shyness". Both types of "case" are excluded from this report.

(2) Where the difficulty was more pronounced and self consciousness and sensitivity, both with home reasons for shyness and involved more of the

personality, and so socialization retarded we called it "neurotic shyness"; relatively easily reversible.

(3) Where there was definite psychogenic stress with a reaction of decided withdrawal, we called it a "schizoid psychopathy".

(4) Where the strain factor was early and immense, and so the child's nearly absolute withdrawal a necessity – such as in gross somatic and psychological deprivation from infancy – we called the expected resultant reaction "psychogenic autism". The proviso was that there be no organic factors and that the autism was still relatively reversible and without profound speech difficulties – such as mutism or idioglossia. However, in this respect, we imagine that the ferral child could become profoundly autistic, if deprivation is maximal and barely supporting of physical life.

(5) Then, contrary to present day thinking, we thought that a "schizophrenic process" is distinguishable from (6) cryptogenic and organic autism both clinically and prognostically.

In general the schizophrenic process

(a) seems more active with definitely larger psychogenic antecedents.

(b) There seems a more direct relation between removal of strain and amelioration of this reaction.

(c) The condition begins more often after infancy.

(d) In a fluid phase, the extent of disarticulation is greater in all dimensions of personality: affect, conation and perception.

(e) The resultant picture resembles adult schizophrenia, with characteristic paranoid delusional trends and a facility for hallucinations. The process is a forerunner to an illness declared no later than in adolescence or early maturity. (within 10 years or so)

(f) The need for sameness and for control with obsessive compulsiveness is never a leading feature.

(g) There is an impression of active withdrawal rather than an incapacity for forming relationships.

Whirling and other pathognomonic phenomena described by others were not found in this series, but hyperkinesia, dancing, musicophalia etc., were observed but not useful in differentiation between cryptogenic autism and schizophrenic process.

Why we felt that this shading distinction was useful will be elaborated on in the discussion.

(6) Cryptogenic autism is characterized by minimal "strain" in the life of the child with yet no discoverable factors really accounting for the degree of autism; whereas organic autism is characterized by at least the same degree of autism as in the cryptogenic kind with yet a known organic factor present.

(7) Finally, in brain injury there was a decisive and grosser organic factor with higher level neurological changes (viz. parieto-temporal lobe syndrome etc.) as well as some autism.

It is, of course, not possible to describe exactly how we placed each case on the spectrum. Suffice it to say we had the aforementioned organization for making observation and judgments, and to add that often enough we wondered on which side of this shading spectrum a case ought to be placed. Usually our doubts were resolved by time. The case extracts should further demonstrate our thinking and practice.

Note on the Morphology of Phantasy

We became increasingly impressed by the "structure" of phantasy material and its apparent direct relation to the degree of autism and advancement in the schizophrenic process.

The phantasy material was gathered from:

(a) A verbal elaboration of the fears of the child. For instance, one case (No. 1), was afraid of any movement for which he was unprepared; even a falling leaf.

(b) The dream work and its elaboration.

(c) The projective material obtained from psychological tests.

(d) Verbal and play communication in the play room.

Communication in the play room was categorized as follows (12)

1. What toys and what room spaces were used.
2. What actions and interactions (physical movements) with objects.
3. What affects were shown towards toys, examiner and task.
4. The organization of play.
5. The configuration of patterns of play.
6. Content and theme of play.

After making allowances for age, cultural grouping, degree of interest and awareness and ability to recall (viz. dreams), and interference with communication (viz. in dysplasia or stuttering), we felt that in the organization of perceptions and in their elaboration in phantasy, despite the difficulties of final communication, it was worthwhile categorizing the structure of phantasy and looking for correlates with the clinical picture in the child. Thus we classified phantasy as:

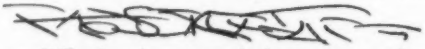
1. Unitary: If the story (or play sequence) began at one point and ended at another in logical (even if autistic) sequence. In form this could be represented by a straight line A————————B.

2. Montage: If the story meandered and digressed but returned to the main theme

3. Fragmental: If the sequence was broken off at irregular and apparently inconsequential intervals A——B———C————D.

4. Amorphous: If there was diffusion and formlessness and vagueness; with no beginning other than vocalization and no end other than its cessation.

5. Chaotic: If there was complete disorganization of contents.



Where there was difficulty in appreciating parts and wholes, faulty body perception, inability to synthesize, and obvious defect at the symbolic level of mentation, there autistic "defect" was present and the form of phantasy would be montage at best, and chaotic at worst.

Since phantasy is the most basic form of symbolic mentation, nearest to the process that interprets perception and affect, it is valuable to work back to it in diagnosing the child's inherent disorder.

Table V shows the correlation between our diagnosis of the morphology of phantasy and diagnosis.

TABLE V: MORPHOLOGY OF PHANTASY IN VARIOUS DIAGNOSTIC CATEGORIES

No.	Initials	Diagnosis	Phantasy
3.	L.B.	Schizophrenic process	1. Chaotic, fragmental 2. Not recorded 3. Chaotic
4.	R.P.	Schizoid psychopathy	1. Not tested 2. Montage 3. Montage
10.	R.H.	Schizoid psychopathy	1. & 2. Montage 3. Unitary
12.	A.G.	Psychogenic autism	1. & 2. Concretism and unitary 3. Montage
16.	B.W.	Cryptogenic autism	1. & 2. Concretism and unitary 3. Fragmental
17.	J.P.	Schizophrenic process	1. 2. 3. } Chaotic, fragmental
18.	D.L.	Schizophrenic process	1. Montage, overideational 2. Montage 3. Fragmental
19.	L.H.	Neurotic shyness	1. Unitary, imaginative 2. Not recorded 3. Unitary
21.	K.E.	Cryptogenic autism	1. DAP—disorganization 2. Not recorded 3. Fragmental

LEGEND

Result. 1. = Projective Tests
2. = Dreams
3. = Play

Prognosis

At each diagnostic conference we hazarded a prognostication to sharpen our thinking and learn from the subsequent turn of events. On reaching an opinion we considered as before:

(1) Whether the resultant stress reaction pointed to an innate "defect" in the child or whether it was compatible with the "strain".

(2) Whether stresses, both the original in the environment and the circuitous one set up by the child's own complaint, were alterable and capable of amelioration.

(3) Whether the ego could be strengthened.

(4) What personality assets could be brought to bear and made to serve the child's organization in society and within himself.

In the end we kept the modest and usual categories of clinical guess:

1. Good.
2. Indifferent – guarded.
3. Poor or same.
4. Worse.

with respect to the inner mental picture and the ability to function at home, at school, and later in life.

Follow Up

At the time of writing this paper we had organized a special follow-up enquiry, though from time to time we would have received school reports, the impressions of the educational social worker in contact both with the clinic and the school; casual reports from a member of the staff, meeting the child, or one who knows him in this circumscribed community, and telephone calls from the parents or cards from them or the children.

A social worker, with no knowledge of our study and new to the clinic, was asked to follow up and reach an independent opinion. She approached all the cases by letter; those who failed to respond, by telephone; those who failed to respond to this, by visits.

In all cases the follow up opinion is registered as a composite of parents —child—school and social worker and we feel that this opinion is a fact.

Results

These are conveniently given in Table VI.

The Natural History of Autism

Diagram II was compiled from the result of our investigation, treatment and follow up. The solid arrows indicate our strength of opinion backed up by a number of cases. Our doubts on each case are questioned by a mark. Our intuitive opinions, which we felt may be verified by a larger series, are indicated by an interrupted arrowed line.

DIAGRAM II

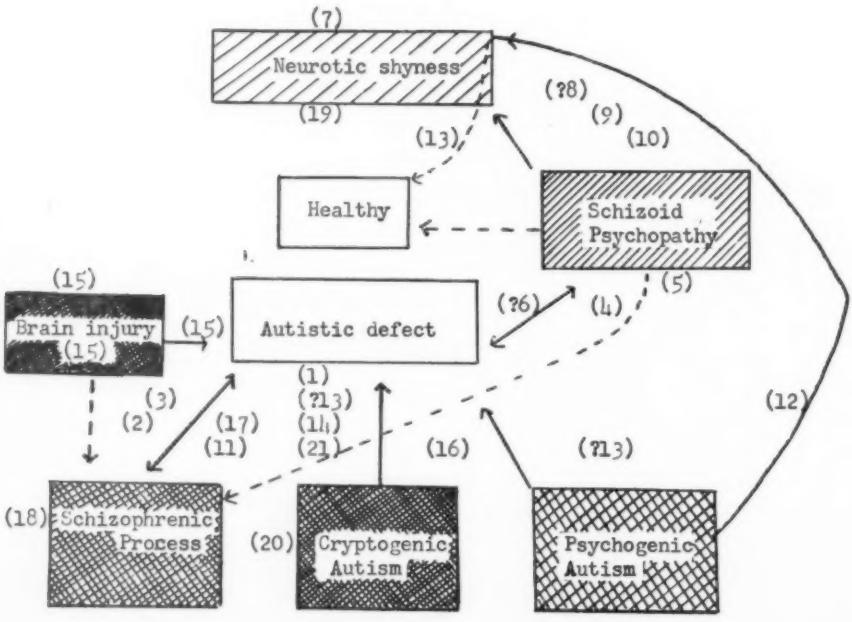


TABLE VI: CASE MATERIAL

Number & Initials	Age when first seen	I.Q.	Diagnosis	Prognosis	Follow-up & Outcome
1. R.B.	5	73	Cryptogenic autism	Good, that is may resolve into autistic effect	4 years—much improved (continual), but still morbidly fearful. Autistic defect. (A.D.)
2. E.W.	10	72	Schizophrenic process	Good— "	2 years—much improved—remains troublesome at school. (A.D.)
3. L.B.	11	70 — 80	Schizophrenic process	Good— "	4 years—much improved but dull and quiet. A.D.
4. R.P.	9	83	Schizoid psychopathy (with organic factor)	Indifferent. Likely to remain psychopathic	1 year—improved but anxious. 3 years—improved but remains essentially A.D.
5. B.M.F.	10	93	Schizoid psychopathy (with organic factor)	Indifferent	1 year—improved but still schizoid
6. R.A.	7	90 — 95	Developing schizoid psychopathy (severe psychogenic strain)	Indifferent. Likely to remain psychopathic	5 years—improved some ? Autistic defect (A.D.)
7. N.R.	13	109	Neurotic shyness	Good. May resolve into normative shyness	5 years—"growing out of it"—working. Shy.
8. S.F.	6	not tested	Developing schizoid psychopathy	Good. May resolve into neurosis	4 years. Neurotic shyness.
9. B.P.	7	125	Developing schizoid psychopathy	Good. May resolve into neurosis	2 years & 5 years. Continual improvement, but set back by each change. Neurotic shyness.
10.	8.6/12	103	Schizoid psychopath	Good—may resolve with shyness as a feature	4 years—Advancing in school and speech. Tends to regress at times. Neurotic shyness.
11. M.M.	15	70	Schizophrenic process	Indifferent	5 years—admitted and re-admitted to mental hospitals. Same.
12. A.G.	6.10/12	100	Psychogenic autism	Good—may resolve but with psychopathy or at best—neurosis	4 years—Wonderful improvement at school, at play and at home. Neurotic shyness.

TABLE VI — *Continued*

Number & Initials	Age when first seen	I.Q.	Diagnosis	Prognosis	Follow-up & Outcome
13. D.G.	5.2/12	86	Cryptogenic autism (with psycho-pathologic factors)	Good—may resolve with autistic defect	3 years—Improved in speech and advancing in school but remains A.D.
14. B.S.	4	88	Cryptogenic autism (with psycho-pathologic factors)	Good—may resolve into autistic defect	1½ years—Less destructive and can be reasoned with. Slow improvement. A.D.
15. G.H.	6	73	Brain injury	Indifferent	1 year—Same. Unmanageable. Parents broke treatment.
16. B.W.	9.10/12	74	Cryptogenic autism (with organic factor)	Guarded. Autistic defect	1 year—Slow improvement with autistic defect.
17. J.P.	5.7/12	70 — 75	Schizophrenic process	Indifferent	1 year—Same.
18. D.L.	13.6/12	95	Schizophrenic process	Indifferent	1 year—Same Pre-schizophrenic.
19. L.H.	5.4/12	94	Neurotic shyness	Good	1 year—Improved in all areas. Healthy.
20. S.M.	4.8/12	not tested	Cryptogenic autism (with organic and hereditary factors)	Poor	1 year—To be institutionalized with schizophrenic process.
21. K.E.	4.3/12	90 — 110	Cryptogenic autism	Good—Resolve with autistic defect	1 year—much improved but with speech and autistic defect.

It will be noted that in the "Dynamic" end of the spectrum of disorders, from neurotic shyness to psychogenic autism, a healthy end point is possible though increasingly unlikely. It is interesting that a case of psychogenic autism though based on physical and psychological gross neglect and deprivation is not easily reversible and may well leave the person with an inherent personality "defect", despite therapy; a defect undistinguishable perhaps from the "defect" of cryptogenic autism. So that once disarticulation from the environment is pronounced, especially if it occurs at early developmental stages, it becomes more liable to a permanent defect than to a reversal.

At the other end of the spectrum where disarticulation as an inherent "defect" is already present this remains, even where in schizophrenia the active process abates or appears to clear up.

Note on Treatment. (Play Techniques)

In the previous article (6) various types of possible treatment were discussed. It was suggested that long term play therapy appeared to be the most promising method of treatment for children and analytically oriented psychotherapy for adolescents.

These methods of treatment were carried out in all the cases reported in this paper, with the exception of Case No. 11 (M.M.) who was hospitalized. The length of time each case was in treatment varied, and depended on the cooperation of the parents, and the likelihood or evidence of definite improvement after several weeks of therapy.

Another variation in treatment depended on the severity of the disturbance and whether it was classified to the left or to the right of the spectral band. If patients were placed on the left of the spectral band, play therapy or psychotherapy was essentially non-directive, as so adequately described by Axline (1). If the children were classified to the right of the spectral band, the therapist who attempted to pierce their "autistic barrier" (4) took a more active part in therapy – and related to them at some point where there was a definite reaction in the activities initiated by the therapist. Once this was accomplished there was visible progress and improvement in the adjustment of the patient.

Discussion

A. Incidence has already been discussed. Obviously we do not refer here to the incidence of "a disease", or its certain pathologic precursor; but to the prevalence of a tendency towards autism in a community. We feel this kind of statistic is all too rare. In psychiatric phenomenology it is probably not very meaningful to absolutely categorize a disorder and it is a better approximation of the truth to plot a case on a spectrum obtained by the total clustering of observations and test results. Having done so, it is more meaningful to find out the incidence of the entire tendency that may or may not result in a well defined disorder, then merely to count the number fallen ill with a particular condition. Finally, wherever a statistic of prevalence is given, clearly it gains in meaning when one knows the texture of the population from which it was lifted.

B. We do not need to justify our methodology because it is a refinement of the classical clinical method. But we are very keen on pointing out that such a method, aided by serious reflection, may take one quite as far in the quest for truth as any of the more fanciful and expensive research tools en vogue. Moreover, there is a great need in psychiatry for this sort of basic pedestrian searching.

C. We cannot gauge how much one needs to justify diagnosis on a spectrum. It would seem, at least in psychiatry, the ideal diagnosis. One suspects that altogether in medicine this kind of thinking on a spectrum would lead to quicker progress.

The general arguments in favour are:

(i) That most, if not all, the psychiatric illnesses are stress reactions which have either become inappropriate or excessive. At any rate, such pathological reactions are hardly ever de novo. They are found essentially in normative function and structure.

(ii) Nuclear forms of aberrant mental reactions usually are clearly recognizable along the developmental axis of the individual and at critical periods they become manifest and sometimes strikingly manifest.

(iii) Probably psychopathology begins with additive strain and alteration or reaction which then ceases to fulfil its original defensive purpose. When the reaction is no more reversible in time, so that it becomes habitual, a "structural" personality change occurs. There is forever an interplay of psychopathologic and somatopathologic (heredo-constitutional and organic) factors. When structural changes are present ab initio, reversibility is unlikely, if not impossible.

(iv) In the statistical normative of the adult population there are "formes frustes", (among people that function relatively well socially) of all kinds of pathologic reaction.

(v) A study of comparative cultures forever points out the relativeness of pathology in mental reactions.

The spectrum reflects faithfully the aforementioned points. Moreover, by taking account of a tendency towards a pathologic manifestation, it leads more surely towards the concept of the natural history of a disorder. This concept, in turn, leads to the most fruitful kind of socratic clinical thinking on specific aetiology: "Why has this case turned out such and that case thus?" Hence a search for more subtle and crucial factors of causality.

It remains to point out the argument in favour of this specific spectrum of the autistic-schizophrenic conditions, where the essential lesion is a degree of disarticulation between the individual and his outer world and eventually between his ego and the rest of his mental apparatus.

(i) Certainly a degree of "autism" is apparent in infants (14) and a degree of schizophrenia exists in nuclear fashion wherever phantasy invades consciousness and perception and affect are "fluid" and conation not able to correct. Thus, "disarticulation" is part of early childhood, and also part of the hypnagogic and the deliriant states, any time in life.

(ii) A tendency to intraversion, withdrawal and shyness is nuclear in human nature — it is as basic as the reflex withdrawal on application of a nociceptive stimulus. When the range of defenses is small and strength is lacking, when the nociceptive stimulus is "burning" e.g. "deprivation", withdrawal and even autism is the major defensive response. To the extent to which the person withdraws, to that extent he is necessarily disarticulated from his environment.

(iii) Probably the balance between a forward flux of libido, supported by aggression and eros, and its reflux in withdrawal, depends firstly on the symbiotic balance with the mother or surrogate, and next on other immediately important figures.

(iv) Then comes the interplay of the somatic "structural" factors, increasing a trend to autism or actually amounting to a defect where full "articulation" with the world is no longer possible.

(v) It is undeniable that the "formes frustes" of autism appear continually in the population.

(vi) One would submit that the Eskimo, the Scandinavian, Anglo-Saxon, and the Bengali are more natively "autistic" than the Latin, Hawaiian or Nepalese. Also that on our standards some Polynesian, Aborigines and sections of the Asiatic population is positively "schizophrenic".

If all this is granted then there is obvious virtue in our spectrum which, of course, would have to be relative to a cultural grouping; not only to a large ethnically determined one, but to a smaller religio-culturally and urban-rurally determined group.

We suggest that following this kind of thinking psychiatric diagnosis can

come nearer to the truth. Consequently one is better able to realize what happens to each kind of person, and so prognosticate more accurately.

Much of what has been said will have justified the distinction between a schizophrenic process and autism. Clearly to the right of the bar, within the spectrum, the interplay of somatogenic factors gains momentum. But the main difference between schizophrenia and what we called cryptogenic autism is qualitative: Schizophrenia is more active a reaction, we suspect triggered by psychopathologic factors; cryptogenic autism is a colder condition, fundamentally a defect, either grossly organically determined or determined by a superimposition or psychopathology on a subtle high neurocerebral defect.

Prognostically and in outcome the difference is that when the schizophrenic gets "better" he is left perhaps with a minimum autistic defect, when he cannot fully articulate with the world and is forever threatening a splitting process on strain. Whereas the cryptogenic autist remains essentially unchanged, though on getting worse he may assume the more fluid elements of schizophrenia (viz. hallucinations etc.); when he gets better he can only return to his original, basic, larger autistic defect.

D. Our concept of the natural history of the spectrum of autism suggests that even large personality involvement, a grave clinical picture can resolve into a neurosis and eventually normativeness, depending on the age of onset and treatment facilities. The dividing line is psychogenic autism where the outcome may be a permanent defect (A.D.) or resolution. This depends on the alteration of fundamental personality structure wrought by early strain — usually a severe form of deprivation.

E. The recommendations we would make follow logically. We would wish that cases were studied systematically and uniformly, with minimal speculation and with a descriptive clinical bias, so that all workers in this field may integrate their thinking, i.e. know that they are all talking about the same kind of thing. Naturally we would be pleased if others adopted our suggestion on diagnosis on the spectrum, in this and generally in all spheres of psychiatry, and refined this tool of thinking. But we would be equally glad to see a valid refutation with a constructive substitute.

A child guidance clinic can do a great deal, not only in prevention of these conditions, but also in early and active treatment and saving of hospital beds. It is needless to emphasize that the sooner we have a firm body of knowledge to hand over to our paediatric colleagues, the earlier they (and the parents and teachers) will suspect a disorder and apply for guidance and treatment. It will have been noticed that we feel already that a point is reached where it is futile to describe a "natural" history of such a condition by reference to untreated or at least unguided patients; so that it is assumed that they will find their way naturally to a guidance (or similar) centre, located in the community and the events will unfold from there. It is urged that a good guidance staff can do more than they have been disposed to think with such children.

Summary

Twenty-one patients with condition varying from neurotic shyness through autism, to brain injury were described, categorized and placed on a spectrum of autism. Criteria for diagnosis have been developed with consequent increase in the accuracy of prognostication and a more effective approach to treatment. The outcome of our experience with these children over a 5½ year period is discussed. A format for uniform clinical examination and investigations has been suggested; alongside this we have described the usefulness of categorizing the morphology of phantasy.

The natural history of "autism" as we see it has been graphically described. The paper contains clinical excerpts on some of our cases.

Appendix

METHODS OF CLINICAL INVESTIGATIONS

1. *Method of history taking*

Information gathered routinely over a period of weeks, for the intake conference, subsequently leading to the diagnostic conference, was compiled by a social worker, psychologist, and doctors engaged with the patient. It was noted as follows:

A. Complaints
   1. Problem according to parent(s).
   2. Problem according to school (or equivalent).
   3. Problem according to child.

B. Functional enquiry
   (i) Eating habits.
   (ii) Digestive disorders.
   (iii) Habits of elimination.
   (iv) Disorders and attacks of
      a) circulatory system
      b) respiratory system
      c) genito-urinary system
      d) endocrine system
      e) osseo-muscular system
      f) nervous system, inclusive of vision and hearing
      g) skin etc.
   (v) Sleeping habits.
   (vi) Special disorders.
   (vii) Thinking disorders.
   (viii) Habitual manipulation of the body.
   (ix) Emotional habits and attitudes.
   (x) Antisocial trends.
   (xi) Sexual difficulties.

C. Progress at school.

D. Other complaints.

History of present complaints:
   a. Time and type of onset and development of each symptom.
   b. Family attitude and methods of correction.
   c. Previous diagnosis and treatment.

Family History:

Grandparents Parents Siblings	Ages, occupations, Ethnic group, religious affiliations, educational level, state of health, cause of death, emotional state and temperament. Personal relationship to patient.

Home circumstances:
   Type of home and whether owned or renting.
   Neighbourhood and relation.
   Length of residence and previous location.
   Family income.
   History of reverses in family.

Contact with social agencies.
Family recreation.
Home emotional atmosphere
a) in general
b) dominant person
c) love ties and aversions

Development history:
Age of parents at child's birth.
Their respective motivation towards begetting this child – planned, wanted, accepted.
Mother's health during pregnancy – delivery.
Health as infant.

1. Feeding
Breast fed – schedule.
Weaning – completion of schedule.
Eating alone – food fads.
2. Toilet
Bowel training – initiated – completed.
Bladder training – initiated – completed.
3. Speech
Words – sentences – speech.
4. Sex habits
5. Neuroticisms

Schooling:
Age at starting
Present grade
Relation to teacher
Standing in class
Relation to pupils
Games and sports
Other activities

History of past illnesses: (in chronological order)

Personality:
Record description a) self
b) parents
c) clinic
Positive assets.

2. *Method of Clinical Examination*

We have found that the systemized schema for the clinical investigation described in the initial paper (6) has helped us considerably in the uniform study of the natural history of this spectrum of disorder, in establishing criteria for classifying them accordingly, and hence in establishing criteria for treatment and prognosis, if not in advancing our ideas on aetiology. In this connection, we discovered latterly that in paying attention to the morphology of projective test responses, and observation of play, we had a further tool in grading the depth of autistic-schizophrenic disturbance.

The following is the modified format for our clinical examination. It will be observed that the logical sequence is aimed at appraising the larger, more important and central observations first and then working to the more detailed and peripheral ones.

Schema

I. *Behaviour*:

At home, school, in the consulting room and playroom.

1. Interpersonal Relations
   With mother, father, siblings, peers, authority etc., in that order.
2. Relations to self and body image.
3. Relation to objects.

In these three relations we noted which was preferred and then the total and separate appreciation of wholes versus parts and the need for sameness.

4. Speech.
   Here we noted a spectrum of disturbance in communication varying from mutism, idioglossia, ecolalia, dysphasia and dyslalia to negativism in normal speech.
5. Psychomotor functions.
   a. Level of consciousness.
   b. Kinetic system.
   c. Autonomic system.

II. *Intrapsychic function*:

1. Cognition with respect to all senses inclusive of time and space. Here we made a special note of the perception of pain, physical or psychic, and the reaction to any new stimulus. We noted whether, for instance, there was blunting to physical danger and heightening of fears.

2. Mood

Changes were noted in the direction of flattening and impassivity and also splitting varying from impulsivity to incongruity.

3. Conation and Level of Intelligence.
   a. Intelligence: native and performance
   b. Quality of thinking
   c. Relation to reality
   d. Phantasy as in fears, play, projection tests and dreams

(A special note was made on the morphology of each phantasy recorded).

III. *Other Phenomena*:

1. Compulsiveness
   With people, self, objects and thinking.

IV. *Psychological Tests*:

Psychological tests were an integral part of investigations and invariably the scores of these tests were in accord with clinical investigation and led more surely to formulating the diagnosis. They were administered in the course of the appraisal of the child for treatment and varied according to the age of the child and his or her ability to verbalize or communicate.

Intelligence tests used were:

1. The Goodenough-Draw-A-Man Intelligence Test.
2. The Revised Stanford Binet Intelligence Test.
3. The Wechsler-Bellevue for Children.
4. The Wechsler-Bellevue Intelligence Tests.

The Projective tests used were:

1. The Thematic Apperception Test.
2. The Children's Apperception Test.
3. The Rorschach.
4. The Draw-a-Person Test.

With the foregoing data available the diagnostic appraisal was formulated by the entire clinic staff and recorded as follows:

3. *Diagnostic Formulation* (synthesizing essential points and categorizing the disorder)

4. *Psychopathology*
   1. Hereditary and constitutional factors
   2. Environmental factors
   3. Developmental factors
   4. Intrapsychic factors
      a. Formulation of essential conflicts
      b. Leading mental mechanisms employed
      c. Psychosexual phantasy (theory)
         Sexual identification – level of libidinal arrest
      d. Phantasies, conscious and unconscious
         (1) Dreams
         (2) Play

5. *Diagnosis on the "spectrum"*

The crucial questions we asked of the material were:

1. Do the psychogenic (environmental and development) strain factors account for the quality and size of the "autistic" reaction, or is the reaction quantitatively, if not qualitatively in excess of the strain?

2. What would be the effect on the reaction if the strains were removed now or soon?

3. What was the time of onset of this disturbance?

4. What, if any, were the physical factors involved? And finally, in view of all this,

5. What was the extent and depth of disarticulation between this child and his world?

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Résumé

L'objet de ce travail est de décrire notre expérience de cinq ans et demi sur l'autisme et la schizophrénie auprès de 21 enfants dans une clinique communautaire pour l'enfance. Connaissant assez étroitement la population de la ville où nous avons fait nos recherches et qui fait partie d'une métropole, nous en avons pris avantage pour jauger certains facteurs dans l'épidémiologie de cette maladie: particulièrement sa prévalence et sa répartition d'après les sexes, l'âge et le groupe ethnique. Les 21 patients "autistiques" représentaient .06% de la population totale des enfants et des adolescents et 5.1% du nombre total des patients de la clinique. Sur 9 patients masculins, on en comptait 1 féminin

et c'est dans le groupe d'âge 5-9 ans que se situe la plus haute fréquence des diagnostics, soit 57.1%. Tous les cas, moins 4.8%, ont été diagnostiqués avant l'âge de 14 ans. La majeure partie de ces enfants étaient anglo-saxons, bien que les juifs dépassaient légèrement la majorité dans la population totale de la clinique.

Nous décrirons l'approche méthodologique de notre travail clinique, i.e. la méthode de l'histoire de cas, des examens en cours dans la clinique et de la recherche spéciale concernant cette série de cas. Cette recherche spéciale s'est appuyée sur un schéma testant au point de vue clinique les fonctions intrapsychiques et extrapsychiques et leur rapport, principalement en ce qu'elles s'appliquent au trouble autistique, ainsi que sur une batterie de tests psychologiques tels que: le Goodenough Draw a Man, le Stanford Binet revisé, le Wechsler Bellevue pour enfants et des tests de projection. Nous démontrerons comment nous avons organisé les données subjectives et objectives en vue de formuler un diagnostic et de déterminer la psychopathologie en pesant les facteurs hérédo-constitutionnels, les facteurs du milieu et du développement et les facteurs intrapsychodynamiques. Comme instrument spécial dans notre investigation, nous avons, pour déterminer le début et le degré du trouble, utiliser une classification de la morphologie des fantasmes (exprimés par l'inconscience, le rêve semi-conscient, les symptômes et le jeu).

Nous les avons classés sous les catégories suivantes: fantasme unitaire, organisé, fragmentaire, amorphe et chaotique. En comparant nos données sur la morphologie des fantasmes avec celles qu'a révélées le jeu par rapport aux résultats des tests psychologiques qui, de leur nature, sont objectifs, nous avons trouvé une étroite corrélation.

Nous avançons l'hypothèse que le syndrome de l'autisme, et peut-être de tous les troubles psychiatriques, devrait être envisagé selon une échelle mobile: la racine de quelques manifestations symptomatiques se trouve dans un cycle qui va de la timidité et de l'infantilisme à peu près normaux à des symptômes névrotiques et psychopathologiques, le degré de ces manifestations augmentant vers la schizophrénie et let atteintes au cerveau Nos arguments en faveur de cette hypothèse sont que:

1. les manifestations de l'autisme, bien que pathognomoniques selon une constellation qui forme un syndrome typique, sont disséminées à travers la population normale et névrotique;
2. les formes nucléaires de ces réactions mentales d'aliénation persistent chez l'adulte autrement normal et ont été observées avant et après une dépression à des périodes critiques de stress;
3. probablement, outre la susceptibilité d'une population qu'un passé prédispose à la somatopathologie, se trouvent des tensions psychopathologiques qui ont un pouvoir cumulatif et progressif et qui se reflètent en des réactions pathologiques progressives;
4. semées à travers la population se trouvent encore des "formes frustes" de cette condition que nous avons été amenés à qualifier de "défaut autistique";
5. l'anthropologie comparée signale la relation qu'il y a dans la pathologie de ces réactions mentales.

En étudiant de près nos cas échantillonnés sur notre échelle mobile, nous avons pu arriver à formuler qu'on point particulier s'ajoute à la pathologie sous-jacente considérée dans son ensemble, entre ce qu'on a appelé "l'autisme psychogénique" et "l'autisme cryptogénique". Les manifestations du premier état

clinique peuvent se rapporter en majeure partie à la pathologie psychologique alors que celles du dernier ne peuvent pas l'être. Nous postulons donc que, d'après ces cas sur notre échelle, surgit dans l'individu une désarticulation essentielle avec son milieu, une cassure dans plusieurs ou toutes les fonctions majeures de son ego en évolution Nous ne pouvons dire ce qu'est la nature de cette désarticulation, si ce n'est qu'elle n'est pas d'abord psychologique. Les questions cliniques concises qui nous ont permis de poser notre diagnostic avec quelque assurance, et en faire découler des critères utiles pour le pronostic et la thérapie, sont:

1. les tensions psychogéniques, y inclus celles du milieu et du développement, sont-elles une cause de cette réaction?
2. quel serait l'effet sur cette réaction si l'on pouvait faire disparaitre ces tensions, à l'aide d'un processus de rééducation?
3. à quel moment a débuté le trouble?
4. dans l'image clinique, quels ont été et quels sont les facteurs physiques?
5. quelle est l'étendue et la profondeur de la désarticulation de l'enfant avec son monde?

Au moment d'inscrire un cas sur notre échelle mobile de diagnostic, en toute humilité, nous formulions un pronostic: bon, réservé, pauvre, mauvais. Après avoir suivi pendant une période de 1 à 4 ans les cas dont nous avions fait l'évaluation, les résultats obtenus ont concordé de façon remarquable avec le pronostic donné — pas un cas n'a fait exception.

En définitive, ces instruments cliniques et cette expérience nous ont permis de spéculer sur l'histoire réelle du "spectre du trouble autistique". Nous avons postulé qu'en partant de la timidité névrotique et en passant par la psychopathie schizoïde et l'autisme psychogénique, il y a possibilité, pour les enfants et les adolescents, de croître et de se développer normalement; mais, de l'autisme cryptogénique, de la schizophrénie ou des atteintes au cerveau, même si une remarquable résolution est réalisable, il demeure un "défaut autistique" variable lequel, plus tard dans la vie, peut être et, probablement, sera une cause d'un trouble schizophrénique Nous espérons que d'autres cliniciens standardiseront leurs méthodes d'observation et d'évaluation, comme nous l'avons fait nous-mêmes, afin qu'il leur soit possible de nier et/ou de confirmer nos conclusions et de développer d'autres théories.

Nous croyons opportun de faire remarquer ici que, si des procédés cliniques s'avèrent efficaces dans une clinique pour l'enfance, ils le sont non seulement aux fins de poser un diagnostic précoce mais encore pour traiter un trouble en sorte que pourront être évités l'hospitalisation, les traitements physiques et la cristallisation de symptômes en un processus schizophrénique bien établi.

TRAINING PSYCHIATRIC NURSES — A RE-EVALUATION*

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About 1850, the Quakers, from their long experience with hospitals, were evolving a system of care for the mentally ill which has come to be known as "moral treatment". They felt kindness, consideration, and respect for the dignity of the human spirit would enable mentally ill persons to recover from their illnesses. However, as mental hospitals became both larger and more numerous moral treatment became a very small portion of the total treatment of the mentally ill and its influence lessened accordingly.

In 1931 Harry Stack Sullivan started a highly successful treatment ward in Shepherd and Enoch Pratt hospital. He based his treatment upon his theory of the interpersonal nature of emotional conflict, but his methods resembled those used by the Quakers nearly a hundred years earlier. He taught Psychiatric Nurses how to create interpersonal relationships with schizophrenic patients and the results were highly therapeutic.

Sullivan's discovery of the healing effects of interpersonal interaction seems to have been overshadowed by the wave of interest which accompanied the development of the physical therapies in the 1930's. Unfortunately, with these therapies came the belief that patients who did not respond to them were at best incurable and at worst wilfully negativistic. The importance of the interpersonal environment was seriously under-estimated for twenty years and is only recently having an important renaissance. The recent books of Stanton and Schwartz (1) and of Greenblatt, York and Brown (2) reflect this renewed interest in the interpersonal aspects of psychiatry.

This type of emphasis on the treatment of mental illness, as Sullivan realized, has large implications for psychiatric nursing. The psychiatric nurse can no longer be one part physical nurse and one part benevolent jailer. She must be prepared and able to enter into specific interpersonal interactions – that is interpersonal relationships with the patients who are under her care. The interaction with the nurse, and through her with the other patients, is itself the therapeutic instrument.

For a time the realization of the importance of the nurses led to considerable concern with the personality requirements of a "good nurse" and the academic requirements of curricula for training these "good nurses". Very little thought was given to the situation in which these nurses were to practice their skills. Furthermore two difficulties arose immediately; firstly how is a "good nurse" defined, and secondly, how can enough of them once defined, be recruited? Most hospitals were, and still are understaffed and therefore forced to accept any applicant who does not suffer from a major personality disorder. This exigency leads to a further problem. How can such an unselected group be expected to learn enough to be good nurses? A discontinuity had been created such that the role was defined as being "special" but the number of incumbents required made it necessary to fill it with "ordinary" people. Fortunately, for the large hospitals, a great deal can be done with "ordinary" people, if they are properly motivated, suitably oriented and consistently directed. This paper is a contribution to the rapidly growing body of knowledge about the motivating, orienting and directing of psychiatric nurses.

In 1954, the authors set about the task of changing a rather static and traditional mental hospital. Details of these changes are reported elsewhere (3) suffice it to say here that extensive structural changes were made in the administration in order that proper direction be given to the nurses and in

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order that the nurses could have access to sufficient equipment for carrying out an active program. A group of senior nurses[1] was trained in the techniques of ward administration – the creation of a therapeutic milieu – and at the same time they were taught some of the techniques of group therapy. It was hoped that they would be able to pass this training on to other groups of nurses on the wards so that a fan-shaped pattern of re-learning would take place originating with the doctors but having its maximum effect on the wards. The formal training process for psychiatric nurses has not been changed as yet.

Our program of change has had an encouraging degree of success. Total hospital population has dropped in spite of a rise in the admission rates and there has been a decrease in the less desirable methods of controlling patients.

TABLE 1

	Admissions	Total Population Dec. 31st
1954	533	1880
1955	683	1784

TABLE 2: CHANGES IN THE USE OF METHODS OF CONTROL

	1955—Jan. 18–31	1956—Jan. 18–31
Restraint	78 patients for a total of 4170 hours	7 patients for a total of 90½ hours
Seclusion	19 male patients (hours not recorded)	4 patients (hours not recorded)
	31 female patients for a total of 2160¼ hours	36 female patients for a total of 572 hours
E.C.T. to control behaviour	58 female patients received a total of 149 E.C.T.	9 patients received a total of 26 E.C.T.

(It is estimated that only about 10–20% of this change is due solely to the use of tranquillizing drugs).

There are also less quantifiable but easily perceived improvements in "ward climate", including a tremendous rise in the number of fully continent patients, a much higher level of interaction, and a generally improved level of social operation. Perhaps as important as any other factor are the numerous requests being received from nurses that they be left with their own groups of patients on wards that until recently were considered to be the most undesirable in the hospital. These requests are being made because the nurses are seeing improvement in their patients, once considered hopeless, which they feel their efforts have achieved. However, we were far from being completely satisfied with these results; there were areas which we felt had been untouched by the program. Our hospital, like most hospitals of its size was required to deal with a wide variety of patients. They may be classified into five groups, each with a characteristic ward pattern:

1. The mentally ill (a) the acute (b) the chronic – 55% of total.
2. The physically sick, people presenting medical, surgical, gynaecological and occasionally obstetrical problems, 4% of total.

[1]The term "nurse" throughout refers to a psychiatric nurse trained in a three-year five-hundred-hour in-training course. Admission to the professional organization requires standing in University supervised examinations. (4)

3. The aged bedridden, 10.2% of total.
4. The ambulant aged, both psychotic and non-psychotic, 24% of total.
5. Tubercular patients, 6.5% of total.

Clearly, the predominant need of about 20.7% of our total population is good physical care, while very little special physical care but rather a psychologically therapeutic milieu is required for another 55%. The ambulant aged probably requiring at different times both types of care.

The crucial question to ask about psychiatric nursing training is, can nurses be trained to fill both the functions necessary in the mental hospital, i.e.; care of the primarily psychologically sick and care of the primarily physically sick? We might start to formulate an answer to this question by noting that the nurse-doctor relationship is by no means the same for both functions. There is a vital difference between the general-nurse-internist relationship and the psychiatric-nurse-psychiatrist relationship. In general medicine the doctor's authority on the precise procedure prescribed is fully legitimated by his special training; his interpersonal relationships with the nurse have relatively minor consequences as long as the nurse carries out the orders. In psychiatry the doctor must prescribe "activities" and "attitudes" to the patient, and he must admit the nurse as a partner in the undertaking in order to secure her cooperation. The more the nurse's role is defined as "doctor's partner", the more her interaction with the doctor – in fact with all of the people in the milieu in which the nurse and doctor function – becomes important. To use a concrete example; if a doctor prescribes a sedative every four hours, his relationship with the nurse who administers it *may* affect the amount of pain which she inflicts with the needle, but probably little else. If, on the other hand, the nurse is allowed to use her own judgment as to when analgesic drugs are required, the doctor-nurse relationship may greatly affect the comfort or discomfort of the patient. Finally, if the prescription is to "guide the patient gently but firmly into useful activity, particularly group activity", the effect of the nurse's relationship with the doctor and others on the treatment team becomes closely woven into what actually takes place on the wards. On the face of it, psychiatric nurses should surely be adequately trained in both psychiatric and physical nursing. However, paradoxically, the differences in skills required and the necessary relationships with peers and supervisors prevent these two functions from being maximized within the same role. We believe there is a strong case to be made for the separation of the two roles with separate training for each.

We realize that we are here flying in the face of the popular conception of "care for the whole man", but there are theoretical grounds for doubting whether the concept of "treating the whole man" is adequate for modern medical practice at all, and especially modern psychiatric practice. Parsons (5) has noted that one of the strains in modern medical practice arises out of the dependent relationship of the patient upon the doctor. This relationship in turn means that there is an unconscious tendency for the patient to attempt to "seduce" the doctor from his specific role of healer of sickness into a diffuse role of comforter, supporter and personal friend. If he yields, the doctor must abandon the role of specialist, interested only in a specific aspect of the patient, and become interested in *all* of the needs and desires of the patient. If the relationship is fully diffuse he finds he cannot deny the patient's wishes without justifying himself as he would with members of his family. This is an untenable relationship for a doctor, as witness the refusal of medical men to treat their families, and their reluctance to treat their friends.

Of all the specialists, psychiatrists probably grant the most diffuse-appearing relationship with their patients, and they have probably done the most to promote the concept of treating the whole man. However, if one observes their conditions of practice, it becomes evident that they take many precautions against entering a truly diffuse relationship, and against treating anything but a very specific aspect of the man. They will not usually perform a physical examination if a patient is to be treated psychotherapeutically. They have rigid rules against "acting out" in the therapeutic hour – that is they refuse to grant the patient a diffuse relationship. Social contact outside of therapy is sternly discouraged, and finally, diffuse demands made by the patient are constantly analysed so that their transference properties are recognized, and the doctor-patient relationship remains specific.

With all of these precautions, the psychiatrist feels able to interact with the patient in specific ways in order to reach a therapeutic goal. The nurse who must perform two specific and different functions does not have clearcut safeguards against falling into a *diffuse personal* relationship with the patients. Hence the sort of status quo that has been reached in many wards where the nurse treats his/her patients either as inanimate objects or children with the use of pet names and general encouragement of dependency, because it is only with children that a diffuse physical, psychological role can be carried out without anxiety or strain. She finds it difficult to maintain the specific *interpersonal interactions* which are required at the same time that she is attending to intimate physical nursing needs which in themselves create a strain toward dependency. For the nurse the strain would undoubtedly be less if the roles were separate.[1]

If there is a reasonable case for the specialized psychiatric nurse, how should she be trained? The task of these nurses will be to establish and foster nurse-patient and patient-patient interaction. They should therefore have a good understanding of people as individuals, but equally they should know how people interact in groups and how norms of behaviour are built up and how sub-cultures such as "ward cultures" are formed. Presumably they should learn to recognize and experience group pressures and group support in a teaching group – therapy class. They should know enough about work groups to recognize strains when they occur in their own, and enough about administration to realize why they have to carry out certain procedures in certain ways. The core of their training should be, in short, psychiatry, personality psychology, social psychology and sociology. This academic material should provide an understanding of interpersonal processes as a basis for the development of practical skills, and more importantly, should provide a broad base of common understanding between doctor and nurse which is essential for the high level of communication necessary in milieu therapy. Efficiency of communication is, after all, a direct function of the number of shared concepts.

The importance of free communication between the therapeutic team has been underscored by Stanton and Schwartz. We add our own example here because it seems to us to illustrate one special point, and because its importance cannot be over-emphasized.

Our problem centered on a female schizophrenic, aged 34 years. The supervising doctor felt that the patient should be treated permissively on the ward. The ward administrator and the ward supervisor did not agree with this approach, feeling that the patient should be made to conform with certain

[1]There is a problem of inequality inherent in the separate-but-equal concept, but not as great a problem as that now encountered where the psychiatric nurse is looked upon as a poor imitation of a general nurse.

ward standards such as getting up at a stated time and taking her meals in the dining room. During this period, the patient was receiving by prescription, permissive individual attention by a special nurse. During this time the patient was orientated, was able to converse rationally for short periods, was keeping herself moderately tidy, and was helping her nurse to carry out some of her ward duties.

The open disagreement continued and was frequently discussed by the relevant staff members over a period of three weeks. During this time the patient continued to improve slowly, and it is important to note that the rest of the nursing staff were aware of the disagreement, themselves agreeing with the ward supervisor although carrying out the supervising doctor's wishes.

At the end of three weeks, the doctor and supervisor appeared to reach a consensus about the patient. Two days later there was a sudden rapid regression in the patient's behaviour terminating in an attack on her special nurse, followed by a return to bed, muteness, incontinence and refusal of food. This condition continued for a few days at which time it was brought to the supervising doctor's attention by a senior nursing officer.

Investigation revealed the following points:

1. After "consensus" had been reached, the supervising doctor had found he was too busy to visit the ward and so was unaware of the patient's regression.
2. The ward administrator constantly forgot to mention the situation to the supervising doctor despite the fact that they met daily at conference.
3. When asked by a senior nursing officer to reopen the question, the supervising doctor immediately had fantasies of doing it in a way that would humiliate the ward supervisor.
4. The ward supervisor and ward administrator had agreed with the supervising doctor for fear that continued disagreement would jeopardize their positions on the ward,

It is difficult to avoid the conclusion that "consensus" was reached by the doctor and ward supervisor in order to avoid the expression of further feelings of annoyance and their fantasied outcome, and that the patient's regression was the direct outcome of the unspoken conflict over her between the significant staff. Re-opening of the discussion led to rapid improvement of the patient; she once again got out of bed, become continent, conversed and cooperated.

Apparently this patient's adjustment was precariously maintained over a considerable period of time despite the staff disagreement by keeping the conflict about her management overt. If there had been a larger common ground in psychiatric and social-psychological theory, it should have been possible to replace this uneasy truce with a genuine consensus. Such a consensus would require much less time of all the persons involved and would serve as a base for planning the next step in therapy.

However, an academic background is in itself no guarantee that there will be a development of skills. Our own three-year training program contained 234 hours of psychiatry, psychology, and social science. Nevertheless, constantly recurring items of behaviour convinced us that there was little translation of this classroom learning into ward practice. This pattern of isolation of theory from practice consisted in the following four items.

1. Psychiatric nurses are able to deal adequately with many and variedly disturbed patients. They deal with them adequately in that they reduce their anxiety, quiet their disturbed behaviour and motivate them to adjust to the hospital environment. However they are completely unable to describe what

they do or why they select a particular way of handling a particular problem — in other words their practise has no relationship to their theoretical learning in the classroom, nor to any other clearly defined referential framework. They are thus unable either to learn, except by trial and error, or to impart knowledge for the future handling of other patients.

2. Constantly occurring poor marks in exams suggested that the material was functionally irrelevant to the ward situation. It was meant to be applicable but was apparently found inapplicable.

3. Many psychiatric nurses with years of service in the hospital believed that attitudes and techniques of handling patients made no impression upon the illness. The disease, in other words, was perceived as fast to all interactional attacks.

4. Apart from a small number of "trusties" few patients had any opportunity to interact with the nursing staff. Apparently teaching the crucial importance of interaction did not lead to any motivation among the nurses toward interacting with the patients. Furthermore, although the *type* of interaction with patients had improved, no sense of the intrinsic worth of interaction seemed to have been developed.

Apparently there were well-developed norms of behaviour among our senior nurses about how to handle patients and these were effective in dealing with common ward problems. Further, since these norms could not be verbalized, they were largely traditional and were themselves learned in interaction on the wards, thus the laughter of the supervisor sanctions the new nurse who tries to apply classroom principles on the wards. It is obvious that a new theoretical system will have very little effect on traditional ways if the traditional ways are unchanged, and the lack of recognition by the old-line nurses of the necessity for therapeutic interaction with patients is the core of the traditional ward norms. Anyone who attempts to interact constantly with patients will be defined as deviant and sanctioned.

When we first started to re-train our nursing officers, one objective had been to modify these traditional norms of ward behaviour. To some degree we have failed in this task as the persistence of the pattern described above reveals. However, Table II, showing a change in the handling of patients, indicates that the norms *have* changed for the better. Our real failure lay in the fact that we had substituted a new set of traditional norms earned in a new interaction nexus, for the old set. The new norms were better than the old ones, but were still traditional in nature; at any point where the newly built "tradition" did not provide specific guidance, there was a tendency to return to older ways of reacting. Analysis of a very small incident which occurred recently will illustrate the implications of changing "traditions".

Recently, a female patient was causing consternation on her ward by impulsively biting other patients and staff members. Over the years she had had Insulin therapy, lobotomy, sedation of all kinds, some fifty or sixty electro-convulsive treatments, and many long periods of seclusion. During the last year under the reorganization scheme, she has been 'activated' with a group of patients and has shown some improvement. On two recent occasions she has bitten other patients. These episodes were followed by a demand from the nursing staff that her teeth be pulled out.

We know what would have happened up until recently. This is a problem of control, and in our hospital, as in many others, routine control of patients had long ago passed into the hands of the Chief Attendant and Head Nurse. A request such as this would have been assented to in the past and the appropriate

nursing officer would have called the dentist and arranged the extraction. If the ward doctor had heard of it and had disapproved of it on psychiatric grounds he would probably have been unable to resist the pressure from the nursing officers. The teeth of biting patients have always been extracted in this hospital and the procedure is self validating.

The very fact that this case was referred through the proper channels shows a change in nursing norms from the traditional toward the rational, although the traditional still persists in the suggestion that the teeth be extracted at all. In this case the matter was presented to the nursing officer whose extra training had made him doubt the wisdom of traditional procedures, especially when they were in conflict with his new knowledge and psychological theory, referred the matter to his supervising doctor who was horrified on psychiatric grounds, at the request. However, he realized the importance of control to the ward staff and instead of blocking the suggestion on the basis of his authority, he decided to invade the traditional normative base of the nurses' suggestion by providing them with rational scientific information and introducing it into a group discussion. First, he investigated and discovered that extractions of the teeth of biting patients had in the recent past had the following results:

Case I: This 39 year old man had been working on his ward, feeding and looking after himself and showing occasional impulsive biting attacks. Following total extraction he became mute and incontinent and had to be spoon fed.

Case II: This 43 year old man was mute and spoonfed. He had impulsive episodes of biting. Following an extraction, done on dental grounds and with the agreement of the patient, there was an improvement for one or two months. The patient then relapsed and showed impulsive episodes of biting.

Cases IV and V: Both of these patients were low-grade defectives who bit. They continued their attempts to bite for a short period after extraction and then ceased with no other recorded alteration in behaviour.

This rather dramatic evidence that dental extraction for controlling psychotics can easily lead to new nursing problems was presented to the ward group for discussion. It soon became apparent that the ward staff were afraid of the patient and the focus of discussion shifted away from dental surgery to the effect of fear on group interaction. Finally, with a heightened understanding of the group process in which they were involved, the staff decided to try new ways of bringing the patient back within the network of social expectations in order to control her behaviour. Specifically they recommended that more individual attention should be given to this patient and that future episodes should not be handled punitively—with electro-shock, seclusion or massive prolonged sedation.

The patient has shown no further episodes of biting at the time of writing, and has been markedly less tense. For the first time she has discussed her biting with one of the ward staff.

It can be seen that all the changes which we have discussed—administrative reorganization, improved communication, proper placing of authority, shift of ward norms, and the use of specially trained therapeutic nursing officers—played their part in effecting a profound change in the handling of the biting patient. The only flaw in our system of reform was that the shift to a rational method of handling a crisis was far from complete. The staff were not yet ready to refer to a coherent, written-down body of scientific knowledge in order to adapt some aspect of it to the handling of their problem.

In a sense this particular failure was built into our method of changing the Hospital. We now recognize that our high rate of interaction with the new Nursing Officers had created the new norms about treatment based on a great deal of factual information. At the time we failed to see that our method of teaching through constantly analyzing specific day to day problems in the light of general principles and similarly analyzing the solutions to these problems, did not teach our Nursing Officers a method of applying their newly acquired framework of reference when faced with the analysis of problems without our support. This failure making it impossible for our Nursing Officers who as previously stated were norm bearers of high prestige to communicate their new knowledge to the rest of the Nursing Staff in an acceptable manner ie; a manner in which its value in the day to day ward management would be obviously superior to the old traditional methods. As things stand at the time of writing, the norms of the Nursing Staff have not changed as markedly as we had hoped primarily because of our failure to provide our Nursing Officers with a method of applying their framework of reference for the rational analysis and solution of problems which they in turn could communicate to the Nursing Staff as a whole.

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Résumé

Le milieu thérapeutique est bénéficiable à tous les malades et constitue souvent le seul traitement du patient passé à la chronicité. La création de ce milieu est la tâche de l'infirmière psychiatrique. Nous sommes d'avis que la pratique infirmière qui inclut des éléments de soins généraux et de soins psychiatriques, impose à l'infirmière un effort considérable et que l'entrainement pour ce double rôle n'est pas économique pour l'hôpital.

Comme les échanges et l'action unifiée entre les médecins et gardes-malades sont essentiels à la création d'un milieu thérapeutique, nous sommes d'avis qu'il est important que les infirmières psychiatriques incorporent les mêmes sciences de base que celles utilisées par le psychiâtre dans son effort pour établir un milieu thérapeutique. Le psychiâtre ne peut pas investiguer et solutionner tous les problèmes de salle. Il est important que l'infirmière sache utiliser les connaissances qu'on lui a enseignées. Il est aussi important que l'infirmière ait la possibilité de décider ce qui lui semble judicieux. Les façons traditionnelles de réagir aux patients, même si elles sont bonnes et humanitaires, doivent être remplacées par l'utilisation rationnelle des connaissances scientifiques pour solutionner les problèmes se rapportant aux patients. Une telle révolution dans les attitudes et les méthodes ne peut être réussie que grâce aux échanges entre les infirmières et les personnes respectées qui utilisent et encouragent une telle approche.

Editorials

STANDARDS

One of the obligations of professional organizations such as the Canadian Psychiatric Association is that they be prepared to serve in an advisory capacity to licensing, certifying and inspecting institutions such as the Medical Council, the Royal College of Physicians and Surgeons, or the Commission on Hospital Accreditation. Such advice is often sought in the area of standards – standards of training courses, of qualification, of accommodation, of remuneration, of service, of professional procedures.

In two important fields, committees of the C.P.A. are proposing to develop standards and both of these groups consider it imperative that the membership at large should be aware of their actions and should discuss their proposals in detail.

An *ad hoc* committee was appointed at the last annual general meeting to enquire into the matter of inspection and accreditation of Mental Hospitals in Canada by an all Canadian agency. The ways and means of operating such an agency will undoubtedly be the subject of long and careful negotiations with various medical bodies. In the meantime, however, it is recommended that the C.P.A. be prepared, when called upon, to offer a set of standards for grading and evaluation of mental hospitals. This committee is now preparing a draft recommendation detailing standards for rating. No Canadian organization, except the C.P.A., offers a body of sufficient professional competence to ratify these standards. It is hoped that when the draft standards are sent to your provincial, district or affiliate branch you will give them thorough consideration.

Similarly the Committee on Professional Standards finds itself wrestling with problems of training, and examination, of growing complexity and importance. For example it has been said that the quality of patient care is significantly improved in those hospitals which are affiliated with Universities for training and research. A delicate question is often posed concerning the standards that a hospital must reach or maintain in order to establish such a relationship. The officers of the C.P.A. cannot avoid participating in such questions of standard, and, if they are thoughtfully dealt with by the members, the Association can assume an appropriate measure of competent leadership in setting and raising standards.

THE FOUR HUNDRED BED MENTAL HOSPITAL

A recent publication by the Canadian Mental Health Association entitled "Mental Health services in Canada – Report: No. 1 – HOSPITAL CARE" has stimulated considerable discussion among Canadian psychiatrists. The report states that it is the first of a series in which will be published the results of the deliberations of a committee of the Scientific Planning Council of the C.M.H.A. devoted to development of mental health programs and study of the rationale underlying such programs.

The first report, after outlining some general areas of consideration to be taken into account in development of psychiatric services, recommends a change in the size and location of mental hospitals – specifically that in future, mental hospitals should be constructed as far as possible, on a regional basis, each to be of about four hundred bed capacity (at the present incidence of hospitalization

in Canada this would mean one hospital per hundred thousand population). It is further suggested that the regional mental hospital should be sited in the proximity of the principal medical centre serving such an area of population. The report offers eight reasons supporting its proposal. Some of these reasons derive from an 'a priori' therapeutic assumption that the social atmosphere of the hospital is of cardinal significance in the recovery of patients. Another reason given needs supporting evidence – that four hundred bed hospitals are more economical in terms of direct financial cost than are larger institutions. We hope this question will be explored in terms of the total costs per patient and not on a comparative per diem rate.

One point that is not sufficiently stressed in the discussions we have heard, and is obviously not adequately expanded in the report, is that the regional hospital and its staff would form the nucleus for all treatment and community psychiatric services for the region. This, to our way of thinking, may be its main *raison d'être*, – in that such a centre can provide continuity of care with the same staff being engaged in outpatient, community, in-patient and rehabilitation services for any one patient. Hinted in the report, but left undiscussed, is the possibility that all psychiatrists in the community, including those in private practice, might be actively involved with the regional hospital.

Some leading psychiatrists are convinced that a major change in the mode of care of the psychiatric patient is due, and hail the report as a pace setting document. The majority of senior members of the specialty, however, are more reserved in their acceptance of the proposal and raise several questions regarding the adequacy of arrangements for chronic and elderly patients; the matter of economy, mentioned above; apprehension that staffing may be more of a problem than anticipated by the authors of the report. We doubt if all the objections to the proposal can be answered on hypothetical grounds and it is probable that this method of hospitalization will have certain shortcomings. It is to be hoped that circumstances will lead to the construction of one or two hospitals on this principle – possibly one in a rural and another in a metropolitan community so that actual experience may serve as a guide.

ON PROMOTING MENTAL HEALTH*

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Up until about fifty years ago psychiatrists were convinced that mental health or mental illness depended exclusively either on physical health or on constitutional characteristics transmitted by heredity. The principle that mental illness was solely brain illness was accepted as an axiom. Consequently, the efforts of all psychiatric investigators were, for many years, limited to research in laboratories in an attempt to discover in the anatomy, physiology or bio-chemistry of the body, and particularly of the brain, the causes responsible for the diseases of the mind.

The great impulse that psychology received from Wund's revolutionary approach, and the establishment of the first laboratories for experimental psychology, greatly influenced psychiatric research, and it was Kraepelin, one of his disciples, and the venerated master of classic clinical psychiatry, who was the first to apply, and with excellent results indeed, the methods and techniques of experimental psychology to clinical psychiatry. It was Kraepelin, also, who strongly influenced by the theories of Virchow, gave great and fruitful impulse to the research on histopathology and particularly brain pathology in mental diseases. His three pupils, Nissl, Alzheimer and Spielmeyer were the first to investigate the microscopic alterations of the cerebral-cortex in the different mental diseases. The results were excellent and, thanks to their work, we have learned a lot about the anatomical substratum of certain psychoses, the so-called *organic* psychoses. The anatomical pathologic method, however, failed to show any pathologic substratum, not only in the neuroses but also in the two great groups of psychoses, which then, as to-day, made up more than half of the population of mental hospitals, i.e., the manic-depressive psychosis, and the psychosis at that time called dementia praecox.

Kraepelin, the indefatigable defender of the theory of the organic origin of all mental disorders, clearly saw the limitations of this anatomic method. It was then that he turned his research, in his Institute in Munich, toward neuro-physiology, neuro-chemistry and genetics.

Greatly encouraged by the re-discovery of the work of Mendel (for so many years forgotten), he strongly encouraged research on heredity in mental illness under the specialized direction of another of his pupils, Rüdin. But the many years of painstaking research carried out by Rüdin and his collaborators and followers also failed to reveal the answer so anxiously hoped for. Though hereditary factors could not be by any means discarded, results showed that it was not possible to give any adequate answer to the relatives of psychotic patients, who, influenced by the emphasis put on heredity, asked the psychiatrist about the destiny of their children or themselves. It was found that it was not possible even to establish what was called the hereditary prognosis of mental diseases.

About this time, however, Bleuler, though also brought up in the classic Kraepelinian school of thought, saw the possibility of bringing Freud's ideas into the field of the major psychoses. It was he who first introduced the psycho-dynamic factor in psychiatry, and he was the first who tried to "understand" even if he could not "explain" the meaning of the symptoms and the behaviour of the dementia praecox patient. This way of approaching the

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disorders of the mind was very encouraging, since, for the first time psychiatrists now tried to establish a direct relationship with their patients, whom they tried to understand. The patients responded positively to this new, human approach. It was Bleuler, also, who described and isolated what he called the 'fundamental' from the 'accessory' symptoms in schizophrenia and showed us the basic characteristics of the schizophrenic way of thinking.

It was possible now to understand another basic phenomenon, i.e., the dissociation in the behaviour of the schizophrenic, particularly obvious in the intellectual and emotional fields. With his discovery of the ambivalence in the schizophrenic patient, later accepted as a characteristic of all human beings, Bleuler was able to enlarge the narrow concept of schizophrenia, as only one disease in what he called the group of schizophrenias. This was possible because he was able to show how, though the overt clinical manifestations of dementia praecox were expressed in a wide variety of external clinical symptoms, they all had in common however, the same basic fundamental disorder.

On the other hand close clinical observation, not only of symptoms, but also of the course of mental diseases, made it possible for Kraepelin, Bonhoffer, Hoche and others to differentiate between two kinds of symptoms in obviously organic psychoses, as for instance in G.P.I. patients. One group of symptoms was called *axial*, as characteristic of the pathological process: the other category was called *reactive*. Though reactive symptoms seemed to be the most apparent and disturbing, it was found that they could be eliminated or at least greatly diminished in certain favourable, environmental situations. It was found, for instance, that agitated patients of this sort became much calmer when they were taken from their isolation in an uninviting and bare room, and put in a general ward. These findings, though apparently minimal, were very important. They showed even to the frankly organicistic-oriented psychiatrists of that time, the great influence that environmental factors have upon the personality and behaviour, even in such a devastating pathological process as G.P.I. They also showed the clinician that some kind of *symptomatic* improvement in the patient's behaviour could be obtained, even if nothing could be done about the original *cause* of the pathological process.

From the mental hygiene point of view, the psychiatrist is now beginning to recognize the great service that public health workers in general have given to mental health, even if their purpose, superficially, seems to be different from that of the mental hygienist.

The Bleulerian approach and the new phenomenological conception of Jasper's effected a definite change in psychiatry – a change that might be called post-Kraepelinian. Under the inspiration of Gaupp and Bleuler, Kretschmer was able to introduce a new direction in psychiatry, the constitutional approach. His studies on the correlation between the physique and the character made possible, for the first time, the establishment of what seemed to be on an objective basis, a gradual evolution between the normal, the abnormal and the pathological personality.

His conception of the bipolarity between feeling, thinking and acting in the personality, has helped considerably in the understanding of the functioning of the personality in health and disease. It also greatly contributed to our present concepts of mental health, now less rigid and static than they were in the Kraepelinian era.

The problem of the psychopathic personality, for instance, could now be approached from a more scientific point of view.

In all these new psychiatric tendencies one can observe, more or less clearly expressed, recognition of the significance of the concepts formulated by psychoanalysis. Freud and his first followers, including Jung and Bleuler himself, very soon became aware that a theory and technique originally developed for the treatment of neuroses, and, more particularly for hysteria and obsessions, could be used, with good results, at least in understanding the psychological mechanism involved, in the two major groups of psychoses, which so far had resisted the investigator. The first studies of Freud and Jung opened a new way for the understanding of dementia praecox, and those of Freud and Abraham, particularly, for the understanding of the manic-depressive psychoses.

Further progress made in the knowledge of the genesis, dynamics and structure of the personality have been of great value for the establishment, at least theoretically, of certain basic, scientific principles on which to build a real, preventative psychiatry.

Psychoanalysis discovered that the main traits of the personality and the future behaviour of the adult are established during the first years of life. It also discovered that the later disturbances in the mental life of the neurotic, psychopathic or psychotic can be understood as the result of a deficiency or a collapse of the defenses of the ego. This collapse of defenses makes possible a return of old and forgotten conflicts, situations and fantasies of early childhood. Psychopathological symptoms were approached as the expression, either of a fight against, or a defeat of the adult mind, by the archaic part of the mind which ignores objective reality and whose reactions are determined only by its violent drives for instinctual gratification.

Unprejudiced observation of the development of the child showed that its behaviour was fundamentally determined by basic instinctual needs, the origin of which were obviously completely organic. The child feels caught, as it were, between his powerful instinctive basic needs and the complete helplessness inherent in his psychobiological immaturity. Through the painful road of frustration he has to learn to tolerate frustration and to postpone gratification.

It was discovered that the first five years are the most important years of life for every individual; the years when he establishes a certain mastery over himself and a constructive and creative approach towards life and the world in which he lives.

The fact that psychoanalysis recognizes the motive force of human behaviour in instinctual needs, with their organic basis, shows why great attention was given to constitution and heredity as factors determining the shape of the personality. Because of the lack of scientific knowledge regarding constitution, psychoanalysis, however, could only work with the other factors, namely the emotional and environmental ones which foster and/or prevent gratification of the basic needs felt by each individual. That is why psychoanalysis turned to the study of the complicated inter-action between the individual and his milieu. First the mother, then the family, and last, but not at all least, the community in which he lived.

Perhaps you may think I have spent too much time on the introduction, even though it is very incomplete and sketchy, of the leading ideas in psychiatry during the last sixty years. I hope it will be clear, however, that at the present time psychiatry is as much concerned with the individual as with the environment in which he lives.

Psychiatry today is experienced enough to recognize that, though there are numerous, well-known, individual and intra-psychic causes for disease, upon

which environment has little or no influence, there are, on the other hand, powerful environmental forces which can, under certain circumstances, shake to its deepest roots even the most stable personality.

If the central purpose in these seminars is to work on and to discuss problems dealing with the mental hygiene of infants and children particularly, it is not solely because of a sentimental and desirable wish to relieve children from anxieties and sufferings which can be avoided. Our purpose has a larger scope. Experience and observations have convinced us that the more healthy and happy we can keep a child during the difficult and painful years of his early development and growth, the more solid and resistant his personality will be against the later impact of adverse environmental influences. In other words, by keeping the *child* mentally healthy, we are carrying on preventative psychiatry for the *adult* he will become. The discussions during these seminars will throw light on how much of this ambitious goal can be achieved in the present condition of our knowledge and culture.

From a very general, very theoretical point of view, one can say that if the pregnant woman is physically and mentally healthy, and does not carry in her constitution the genes of diseases recognized as being truly hereditary, and if the conditions during the period of gestation and labour are physiologically sound, the child, at birth, should be healthy, both physically and mentally. This general principle shows the line we are to follow in our study of the factors that determine the preservation of mental health.

It shows us in the first place that the mental health of the child depends almost exclusively upon the mother, and the incidents and disturbances she may encounter along the long period of gestation and during the traumatic and violent process of giving birth.

This principle has been recognized, of course, by all public health workers in the great majority of the countries who have organized the so-called pre-natal and maternal clinics. In these clinics the pregnant woman is taken care of during the whole of the pregnancy period, and is prepared for the final moment of the delivery. Unfortunately, in the great majority of cases, the kind of medical or hygienic services offered are almost completely focussed on the physical health of the mother, and most of the services are still influenced by the old fashioned idea that if the body is healthy, the mind must also be healthy.

We must admit, however, that the pregnant women receiving this care are given by it a feeling of security and confidence which may equal if not more than equal the value of the medical or dietetical help they may get.

In many cases these clinics are integrated with other medical services and public welfare agencies. This makes it easy for the pregnant women to be quickly transferred to a specialized service if the necessity arises. The social worker, too, who operates in these clinics can give the pregnant woman a considerable amount of emotional security.

Unfortunately the large majority of these services operate without much awareness of the great emotional meaning the birth of a new child has for the mother as well as for the rest of the family.

The birth of a new child automatically alters the equilibrium of the family milieu, all the members of which will respond according to their own personal and specific emotional needs. The service policy of these maternal clinics is guided, when helping the mother or the family concerned, mainly by material and economic considerations, namely that the birth of a new child means a new financial burden. But the emotional influence which the birth of a new child has on the whole family goes much deeper and is of more importance than the

financial one. Even in homes where there is no question of financial problem, the birth of a new child may have considerable impact on all members of the family, to a greater or lesser degree.

And the emotional significance which the birth of a new child has for the mother of a family varies according to whether the child is the first one or not.

The birth of a new child has a great influence on the emotional balance of the older brothers and sisters. The quality and intensity of this emotional reaction varies considerably, and the mental health worker can do efficient preventive work by enlightening parents on this point. There is no doubt that even in those instances where the older siblings show apparent acceptance of the new-born, the birth of the child disturbs the relationship of the siblings with the parents, particularly with the mother. The birth of the new child is always an *emotional wound*, leaving a permanent impact on the psyche of the other siblings. This trauma, however, is desirable in most cases since it can strengthen the older child's ego, and can set in motion its mechanism of defense, thus aiding him to learn to tolerate frustrations and to heighten the threshold of tensions, which is one of the characteristics of mental health.

Rivalry with the brother teaches the child to share and to participate, and in so doing he represses a large part of his narcissistic demands. Circumstances may change these, what might be called physiological and desirable frustrations, into pathogenic or deeply traumatic experiences. This may happen when the ego of the older child is not yet well enough developed at the time of the new sibling's birth – for instance, when the mother becomes pregnant when the older child is still in the feeding stage and has to be abruptly weaned, or when the older child finds itself struggling to overcome the difficulties of the oedipal situation. Also, later on at puberty, particularly for the young girl, the birth of a new baby can provoke an emotional storm which may be sometimes difficult to overcome.

At any rate it is important to let the mother know that the older brother or sister will feel a certain rivalry or jealousy which may take overt expression, and to tell her that this is normal and universal.

Generally mothers feel resentment and guilt when the aggressiveness of the older siblings is expressed towards the newborn child. If the mother is not well guided and informed she may try to compensate by paying too much attention to the older siblings at the expense of the legitimate needs of the newborn.

Mothers should also be told and re-assured about the fact that the older sibling may re-act to the birth of a baby by giving up already acquired habits such as bladder and bowel control, or may stop trying to walk, if the birth occurs at the time when the older one is attempting to gain control of and coordinate his musculature. If the mother has been told in advance about this type of reaction, she will feel less disturbed and, as a result of understanding the difficulties of the older child, she will be in a better position to help him.

There are also other important factors which mental hygiene workers should keep in mind: for example, the degree of acceptance by the mother of the newborn. Under certain circumstances the mother may resent her pregnancy. Strong ambivalent feelings towards the baby may be expressed in deep feelings of guilt, which may result in anxiety and over-protectiveness towards the baby, causing the child later on to become dependent and resentful.

The emotional support and understanding which the social worker can give to the mother will encourage her to express her feelings, thus diminishing her anxiety and having a beneficial influence on the child.

It is convenient to keep in mind that the biological symbiosis between mother and foetus tries to continue itself after the birth into what now becomes an emotional inter-dependency. Even if the mother is not aware of the fact, the baby automatically reacts according to the way the mother feels. The ego of the child during the crucial first year of development is a mere reflection of the ego of the mother. It is through its mother that the child lives and feels following passively, as it were, changes of affects and emotions in the mother. If the mother feels happy the baby will feel content, but he will feel anxious, depressed or aggressive if the mother feels the same.

During the whole period of pregnancy, but more particularly during the last month or weeks which precede the birth, every mother suffers an emotional regression, and even the most well-balanced woman will feel and behave quite differently to the way she felt and behaved before gestation.

In spite of the fact that pregnancy and delivery are normal physiological processes, the mother experiences a series of anxieties and *magic* fears which are always present even though she may not be aware of them. There is a return of the old conflicts and anxieties experienced by the mother during the first years of her own life, not only during the oedipal period, but also during earlier years. This state of regression may be intense enough to endanger the mother's ego defenses, so especially needed by her at this time if she is to fulfill adequately all the new tasks which lie ahead.

The period of gestation is a period of test. The mother's feelings and behaviour at this time give us considerable information regarding her degree of emotional balance and her available defenses, as, similarly, though not as dramatically, her feelings and behaviour at the onset of her menstrual life, and later during every menstrual period, can be an indication of her emotional balance.

The psycho-dynamic relationship between both processes is well known.

It is important to emphasize, however, that these regressive manifestations of the pregnant woman are absolutely *normal and universal* and can be equated to some extent to the emotional regression which takes place in every one of us, man or woman, boy or girl, young or old, when we suffer from an accident or an acute chronic disease of an organic nature.

A clear understanding of all the emotional phenomena which develop during the process of pregnancy and which may express itself in possible peculiar behaviour is very useful for the mental health worker since it enables her to help the mother during the period of pregnancy and prepare her for all the anxieties she will have to overcome; anxieties which may increase in intensity at the moment of delivery and immediately after. The act of delivery represents a separation. *This separation is traumatic both for the mother and for the baby, since it represents the rupture of the most perfect functional union between two organisms.* There are, however, great qualitative differences between mother and baby. For the mother, delivery of her baby is felt as a mutilation. She feels as if something essential is lost, which greatly endangers her mind and body, violently, painfully and cruelly. The baby, on the other hand, finds himself suddenly under the impact of a series of strong stimuli and tensions which he did not feel during the period of his intra-uterine life, where even breath was unnecessary. Quickly, in the matter of seconds, the organism of the new born has to set in motion a series of regulatory mechanisms and reflexes which make possible for him the new life of a "separate".

The process of delivery, however, is not always normal. Difficulties and obstacles may develop which may leave on the organism of the baby, especially

on his brain, traces which can be responsible later on for a faulty mental or physical development, as forceps, anoxia, etc. If the baby is born with, or acquires during the process of labour some sort of defect, this causes in the mind of the mother an understandable narcissistic wound which inevitably disturbs the desirable equilibrium between mother and child, and deprives both of the harmony which is so essential for the normal development of the child's psycho-physical personality.

These facts show clearly how important a normal and relatively short delivery is for the development of the child, not only from a physical point of view but also in order to maintain during the first years of his life the desirable harmony between himself and his mother, as a basis of a solid foundation for his normal development.

The more conscious the mother is at the moment of birth; i.e., at the moment of separation, the more harmonious her relationship becomes with her child. That the separation is accompanied by great suffering and pain only makes the relationship better. This point is extremely important and should be more carefully investigated by physicians and psychiatrists so as to establish clearly the conditions and kind of anaesthesia best suited to delivery.

The capacity which women have for enduring pain and forgetting it, especially labour pain, is well known. One fact is important, however, and that is, that though physical pain must under certain circumstances be avoided, this must be done in such a way as not to deprive the mother of the complete awareness of the birth of her baby.

Once the break of the biological symbiosis of mother and child has taken place, the baby is left in a condition of complete helplessness and dependence on his mother and on his environment. The period which follows is a period of inter-dependency for both mother and child, though the motivations are different, but both will feel a longing to re-establish, in some way, the union which has been interrupted at the moment of birth. This longing for restoration and re-union will accompany the child until his death. In the same way that the womb is for the foetus its most perfect milieu, the mother will be during the first years of the child's life, his only universe.

It will be through the mother that the child will discover, adapt and accept, by means of frustrations and gratifications, the world in which he will live. It is through the mother that the child will first learn how to establish object relationships which, later on, enable him to have a normal relationship with the rest of his fellow beings.

The discovery of the mother as the only source of gratification changes slowly and progressively to a less narcissistic and demanding attitude, the basis of which is established mainly during the first year of life.

It must be emphasized that the first discovery made by the baby is not that of "the" mother but of a "part". First he discovers her breast and more specifically the nipple. The contact of the nipple with the baby's mouth is the first highly re-assuring and gratifying experience which the baby feels after his separation from the mother. It seems then, not only logical, but mere common sense, that if this is the first type of relationship the baby establishes with his mother, neither child nor mother should be deprived of such a rewarding experience, whenever possible.

Too many mothers in our occidental culture leave their children at this fundamental first year of their life to the care of a "hired" mother. Naturally, an emotionally stable "hired" mother may be preferable to an unstable "natural"

mother or one who has not yet succeeded in accepting, as so frequently happens, not only maternity but her feminine role.

Observations show, that when this kind of mother leaves the care of her children in the hands of nurses, strong feelings of rivalry and guilt are experienced by both, with the result that the child frequently develops in a condition of emotional confusion. It is even more evident when the mother changes nurses repeatedly. One must realize that every change of nurse means for the child a new separation, and a new emotional trauma, and in spite of the fact that his psycho-somatic and emotional reactions are of short duration, they still leave a deep trace in the child's personality.

Child psychiatrists are now well aware of the serious consequences which the separation from his mother, during the first 30 months of his life, but especially during the first year of his life, has on the mental and physical development of the child. We believe, however, that the traumatic effect of repeated changes of nurses has not been strongly enough emphasized. We insist on this point since it is a very common situation among families of high social and economic status.

The mental health worker can be of value to the mother by helping her to realize the importance of providing her child with a stable and permanent relationship with herself, particularly during the feeding period, and when this is not possible, and a nurse has to take care of the child, the importance of keeping the same nurse for as long as possible, preferably until the weaning takes place.

There are situations in which a separation of mother and child is unavoidable and unfortunately these situations are rather numerous. The persons responsible for making such a decision must realize very clearly, that, however necessary the separation is, it is never a good solution, either for the mother or the child.

In these extreme cases the mental health worker should know that the best possible solution is to find a foster home for the baby. Such a foster home must have the minimum requirements of stability and performance, so that the child may find a good mother substitute.

The experience of Anna Freud and her collaborators, in the nurseries, which, under the impact of war had to be hastily organized in London, has shown the profoundly upsetting influence which a weekly routine change of nurses had on the children. When, as a result of such observations, a system of continuity was established, and children were no longer exposed to changes of nurses, they became more quiet and happy.

Of all the possible "solutions" for the separated child, the least pathogenic is naturally the foster home. In the choice of a foster home, the emotional stability of the mother substitute is much more important than the physical and material conditions within the home. Outside the foster home, no acceptable solution can be found for the child deprived of his mother, and the mental health worker will oppose strongly any decision to have the child sent to an institution or orphanage.

A similar situation arises with the so-called nurseries or camps for children of pre-school age. All these organizations, though they serve a very desirable purpose, were developed at a time when there was no knowledge or understanding of the emotional factors that we know now are so important for the healthy development of the child's personality. They still continue to operate without being aware that separation of mother and child, even if it is temporary, is traumatic for both.

Often because of strong economic pressure, mainly in big industrial communities, the mother is forced to work in order to complement the insufficient financial income produced by the father, leaving the child for most of the day in a nursery. We should try to persuade our governments, that in the long run, it would be more economical to give financial support to the mother than to allow her to abandon her children.

Another type of separation which can be avoided in many cases and which is generally not much thought about by either pediatricians and families, deals with the hospitalization of the sick child. There are still many doctors and parents who seem to be more concerned with treating the disease than the "carrier" of it. Parents as well as family doctors and pediatricians should realize that it is much more important for both mother and child, that the sick child be treated at home, even if by doing so, both doctor and family find the treatment less scientific and certainly more trouble for them.

We cannot ignore the fact that every organic disease inflicts two injuries, one to the body and one to the mind, and that it is the duty of the physician not to aggravate the psychical injury by enforcing the separation of the child at a time when he is more vulnerable.

There will be cases in which hospitalization is absolutely necessary and unavoidable, but the pediatrician must realize that hospitalization is only the lesser of two evils. With this in mind, the doctor will see to it that the stay of the child in the hospital be not only as brief as possible, but that the mother be able to stay beside the child as long as this is feasible. Whenever possible the child should be told of the reasons why he has to go to the hospital, and everything in detail should be explained to him with complete truth, so that he will feel less shock and will not lose whatever trust he may have in his mother.

It is very common to see, in the practice of adult psychiatry, the deep trace left in the psyche of the patient expressed in deep mistrust of parents, and later of his fellow men, which originated when parents and doctor, in order to get the child to accept anaesthesia for a minor operation, bribed and cheated him with promises and all kinds of subterfuges, and avoided telling him the truth.

Emphasis has been laid on the dangers of the separation of the child from his mother during the first 30 months. This does not mean that separation following that age will not also be damaging. Separation between mother and child during the first 30 months, if it is prolonged will always be catastrophic for the development of the child. It can cause disturbances in the physical and mental development which may be irreversible. Separation after three years of age is also damaging, but not of such serious consequences, since the ego of the child, by this time, is already quite developed.

Another point which might be discussed, though it might seem rather unconventional, is whether or not the child should be sent to school before the latency period is well under way.

Between the age of 3 and 5 years, when the child has to face and overcome all the anxieties, frustrations and renunciations of the oedipal situation, it is essential that he should be in contact with both parents. This is true, not of course for sentimental reasons, but because it is the only way to help the child to develop normally and to solve his unavoidable and necessary frustrations. His emotional equilibrium in later life will depend largely on the way he faces and solves these conflicts.

It is during the second year of life, and coinciding with the training for the control of bowel and bladder, that the child, already in some control of his skeletal muscular system, begins to show his first attempt at independence.

It is also around this time that the father emerges as an important emotional factor in the life of the child, which will reach its climax around the age of 3, and will continue until puberty.

We are firmly convinced that psychologists have not sufficiently emphasized the importance of the presence of the *father* for the normal development of the child, and that separation from the father is also very damaging, particularly between the age of 3 and 10, or even later. The father is necessary so that the oedipal situation may evolve and find its normal solution. This is the best way to prepare the child for a later establishment of normal adult genital heterosexual object relationships. This is the only way to make the individual ego tolerant of libidinal frustration without effecting a pathological regression of the ego defenses. A constructive identification with the father for the boy and with the mother for the girl, which is only possible when they are present, will accept the child to accept his or her masculine and feminine role respectively. In that way the foundations for a healthy and adult super ego will be established. With it the individual will gain self esteem and an ethical and social consciousness which will invigorate and creatively structuralize his personality.

Mental health workers should not forget that it is just at the latency period that the child more or less liberated from the oedipal anxieties, begins to discover with fascination and bewilderment, the world around him. It is at that time, having achieved a rather advanced maturation of the neuro-muscular system, and in possession of all the means of communication and expression, that he feels a strong drive for activity, and begins to look around and expand the field of his interests beyond the narrow circle of his family. But it is also at that time the child begins to develop his moral values, through identification with those of his father, mother and teachers, whom he feels driven to imitate.

Clinical psychiatry and psychotherapeutic experience shows how frequently the adult becomes ill as a result of the failure to establish a pleasant and loving heterosexual object relationship, and that this failure can be tracked back to the very early formative years, when the presence of both parents is so essential for the child.

This failure expresses itself frequently in neurotic manifestations or behaviour and character disturbances, and impulsive neurosis of all kinds, ranging from drug addiction to sexual perversions and delinquency.

If both parents are emotionally well balanced, the child will learn from the mother how to love and feel loved, how to trust and be trusted. From the father, how to respect and be respected. The presence of both parents gives the child a feeling of constant control and equilibrium, the steadiness and strength of which will depend on the harmonious and satisfactory relationship between father and mother. This emotional balance produces an emotional security that facilitates the development of the capacity to guide one's life according to the reality principle, rational judgment and objectivity. In other words it favours the development of logical thinking, and the capacity for abstraction. It can never be sufficiently emphasized that when the child is ready to go to school, he has already learned or gained, in only 5 years, a great control over his instinctual drives, which means a series of renunciations of powerful narcissistic gratifications. The child can accept these renunciations if he finds at home recognition of his "sacrifice". This is felt by the child as being loved, rewarded and praised. *The child wants to feel loved and wanted for what he is, just as he is*, and resents, and rebels very strongly, when he realizes that in order to be loved, he has to renounce most of his dearest wishes and impulses, and must follow and obey rules of behaviour

imposed upon him first by the mother and then by both the father and mother. The child feels forced to accept this situation because of fear; an intense fear originating in the realization of his own helplessness, and the need to depend on the parents. First the child concentrates his fears on the mother. These fears are felt specifically as fears of losing her love, fear of losing the love of his mother, whose tenderness and protection he needs as much as he needs the milk of her breasts. It is only much later, around the age of 3 years that the child feels the fear of being physically punished, or hurt or mutilated or attacked by the father, if the child is a boy; by the mother if the child is a girl.

We should never forget that as a result of this fear the child unconsciously feels in constant danger, and our image of him during these early years may be that of trembling like a gazelle in the bushes.

We must emphasize, however, the fact that basically this fear has nothing to do with the attitude or behaviour of the parents. It comes from the deeper sources of the child's mind, where thinking is still magic and narcissistic, without reality, sense or logical thought. *The most kind, understanding and vigilant attitude imaginable by the parents, cannot avoid but can only diminish the fear.* It would be useless and harmful, to say the least, to blame the parents exclusively for the child's anxieties. But the parents must be informed, however superficially, of the nature of these fears, because if they can reach some understanding of the child's difficulties and anxieties, the child will sense this understanding and will respond.

This consideration is important because of the fact that it is precisely during the first five years of life of the child, the years in which emotional disturbances may emerge, that the adoption of special measures may be required, and the mental health worker can be of decisive influence if he is well acquainted with these problems. Such disturbances may provoke a variety of symptoms in the child, such as excessive dependence on the mother, disturbances in the feeding, symptoms of the gastro-intestinal system, and difficulties in the training, in the new habits of cleanliness, temper tantrums, retardation in the speech, motility and learning, thumb sucking, fears and phobias, etc., etc. All these manifestations are a sure sign that the child is experiencing difficulty in adapting himself to the demands of the family milieu and may originate either in the constitutional make-up of the child, and/or in the characteristics of the family environment, as, for instance, excessive neuroticism of the parents, frequent separation, too early training, rivalry with the other siblings, etc., etc.

On many occasions the child will respond positively when the parents acquire a degree of understanding of the motives of the child's behaviour, as a result of the specialized intervention of the psychiatrist. We want to stress, however, that vigilant observation of the nurse or the mental health worker at the school, too, can give much help to the child and to his parents, if the worker is able to establish an early diagnosis of the behaviour difficulties, and call them to the attention of the parents. It is the parents' own anxieties which prevent them, often from paying the necessary attention to behaviour difficulties, which in some cases can be easily corrected if they are taken care of immediately.

The experiences of the first five years, and the influences to which the child is submitted during this time, as well as the way in which he reacts to them, or tries to solve them, will leave a deep and permanent trace in his mind, which will be expressed later on, during the various development phases of his life.

Because of this and the fact that this period is so much pervaded with

frustrations, anxieties and renunciations, every human being throws a thick wall of amnesia over it.

It is in connection with the child that mental hygiene and preventive psychiatry have their most fundamental and fruitful field of action. The more the mental health worker helps to promote a normal physical and emotional development in the child, the less he will have to work afterwards with him, as an adult. In other words, *the therapeutic activity of the child psychiatrist is by nature not only a therapeutic activity but also a preventive one.*

The role that the school teacher can play when he is well informed is very important. The teacher should understand that the child has endowed him with many of the attributes and trends with which he has endowed his own parents. The school means for the child a kind of continuation of his own home.

The years from five to puberty, are, or should be, for the normal child, the most happy and free from anxiety of all his life, the so-called latency period. During this time the child begins to discover and to unfold himself, and at the same time, with his eyes wide open and with all his senses alert, he perceives and catches the fascinating universe that he sees around him. Such important years for the child are spent in the primary school. Here, for the first time, he will establish inter-personal relationships of a different kind from those he has already established within his family. These new relationships and friendships will greatly help him to a normal development of his own personality.

Among the many children of his own age he will meet at the school, he will choose some to become his real friends and confidants. This type of friendship he will find most helpful and constructive for a healthy ego development.

For the first time in his life the child will feel that he is "taken seriously"; for the first time he will be able to establish a relationship with another human being whom he has "chosen" according to his inclinations and decision, and not a friend who has been "imposed" by the circumstances of his family home.

The mental health worker should be very conscious of the highly constructive value for the healthy development of the child, of these first friendships and relationships established by the child with other individuals whom he considers his equals. It is consequently important that he inform both parents and teachers of the necessity to protect such friendships and, whenever possible, to encourage them.

It is amazing, not to say pathetic, how much a child may resent being separated from his dearest friends, and how much he may blame his parents, if, for the reason of change of school, due to the family moving from one town or one district to another, he has to leave them. Moving to a new house, even without changing school, may be traumatic for the child if he has already established good and friendly ties with children in the neighbourhood. To all these situations the child reacts with resentment and disappointment, and the new relationships and friendships which he will be forced to establish, will bring with them necessarily, a feeling of insecurity and mistrust.

If experiences of that sort are repeated the child may develop a feeling of deep insecurity, his ego may be too restricted and he may feel emotionally isolated.

Parallel to this ego development of the child and the control he is gaining over himself, and the partial mastery he is experiencing over his environment

during the period of latency, a new, healthy and favourable impetus is seen in the development of the conscience of the child as a result of identification with his parents and parental figures, sustained by the one that he has established on another level with his friends.

A healthy development of conscience is only possible when the child wants to imitate the parents of the same sex. For example, when the boy wants to be "like his father" instead of being "in place of his father". This desirable situation means that he has solved in a healthy way his sexualized attachment previously felt towards the parent of the opposite sex. As a result of this, the feelings of the child to the parents are mostly tender.

The fear of being physically punished or of losing love which originated in the genital conflict, either disappears from consciousness or just stays in the background. Instead, the child will feel from now on that he has in himself a kind of censor which will make him feel guilty when he does not behave according to his ego ideal.

This shows us the very important role that the presence of both parents plays in the healthy development, not only of the ego but of the super ego (ego ideal) of the child.

Parents should be in some way informed of the importance of the role which they play in this very important aspect of the child's development. Parents should realize that it is quite normal for a child to respond with protest to suggestions and orders which come from them; this may take the form of impatience, listlessness, forgetfulness and disobedience. On the other hand the child (though he is completely unaware of this), also imitates his parents. From an educational point of view it is important to realize that the child imitates his parents' behaviour at the very same time that he is protesting against his parents' suggestions or orders. He is uncannily keen also in sensing the contradictions which parents so frequently fall into when they preach one behaviour to their child, and then behave themselves in the opposite way. If the parents' behaviour is different from that which they preach to their child (this unfortunately happens too frequently), the child organizes, as it were, two systems of behaviour, one based on what his parents preach and the other on how they behave. The result in the mind of the child is confusion and lack of direction. This multiplicity of conscience goals is very disturbing and makes practically impossible the establishment of the healthy ego ideal which is always necessary for the foundation of creative and healthy behaviour. Exaggerations of this faulty super ego are very common among psychopaths and drug addicts, and especially among chronic alcoholics.

Another factor which might make difficult the establishment of a moral sense of direction in the child is when the child discovers the discrepancy between the values, moral, ethical, social, religious and so on, of his parents, and those to which he is exposed at school, particularly those of his teachers.

The child normally tends to find it easier to agree, at least at the conscious level, with the values represented by his teachers, because his identification with them is less ambivalent than the one with his parents. This situation may foster and even fix (or accelerate) the tendency that every child shows at that age, and which will last until adolescence, to feel ashamed of his parents; adopting an attitude of disdain if not of contempt towards them. This attitude, which is the conscious expression of the unconscious disappointment, originating during the oedipal stage, and which has its origin in the deepest layers of the human mind, should be understood by the parents, so that they will not react with anger or resentment.

Between the ages of 11 and 15, the personality of the child will go through another painful and stormy crisis, the crisis of puberty, the result of the biological process which will finally establish biological sexual maturity. *Biological sexual maturity does not imply, however, psycho-sexual maturity*, let alone psycho-social maturity. Adolescence is a very difficult and complicated period in our lives. The adolescent has to learn how to break with *infantile* family ties and create new ones better adapted to the new roles that he is to play in society. The adolescent feels caught between his passive, regressive tendencies, which demand of him that he remain a child, and the powerful thrust of the biological and social growth of his body and mind, both of which are pushing him to play a new role in life. This is the age at which the youngster struggles to establish his own identity, both psycho-sexual and psycho-social in complete integration; a very difficult process which starts at puberty and is never completely finished.

The adolescent feels, as it were, a hypertrophy of the "I" of his narcissism, and this entails a violent impulse toward freedom and rebellion. But at the same time he still feels conscious of infantile ties which keep him attached to his family.

This desire for independence (which is only the expression of his search for his own identity) forces him to de-valuate and at times degrade, all the values, racial, religious, ethical, social and so on, and all the traditions in which he has been brought up by his parents. Naturally he has to look for new substitutes for the old ones, different from those of his family. Generally, at least for some period of time, the only values in which the adolescent "believes" are exactly the opposite to those which his own family stands for. The general result is that he makes new identifications with objects (people, things or ideas) which he, as a rule over evaluates as a result of his narcissistic "thrust" and the need to break all ties. This struggle is hard and produces deep feelings of guilt, even when the adolescent is not aware of them because of repression. It is essential that both educators and parents understand the profound nature of this adolescent struggle, so that they will not judge superficially what might seem, and actually is, at times, strange behaviour on the part of the youngster.

The physiological maturity of puberty is a deep source of anxiety and worry, and one can assert without exaggeration, that this biological process is much dreaded by the adolescent. It happens, not rarely, that many of the conscious superficial fears of the adolescent are based on his lack of knowledge of the physiology of sex, and one can easily see that information about the physiology of the genital functions could help the adolescent in his fears. This information however, is rather difficult to give, due to the extreme sensitivity and shyness of the adolescent, intensified by his own pre-genital fantasies and misconceptions, which were repressed during the latency period and which try to return.

Parents should realize that their daughter's first menstruation is a traumatic experience of varying intensity, but always disturbing. It can be diminished a little if information is given to her regarding the real meaning of the biological process. Experience has shown, however, that this information should be given to the girl by someone other than the mother. This may sound strange, but it is a well known fact that the daughter feels disgusted, if her mother talks to her about these problems. The mother, too, never feels free enough of embarrassment to discuss these matters with her daughter, though she can do so very nicely with other people's daughters.

Relationships between mother and daughter are not improved when the mother gives the information, but the relationships can improve very much when some other woman gives the information, and when the mother restricts her role merely to behaving towards the daughter in a warm and understanding way, and to showing contentment and happiness because of the event.

It is not generally known, by parents and teachers, that the first seminal emission of the adolescent boy is, for him, as much of a traumatic experience as the first menstruation is for the girl. This may be because parents are unaware of what has happened to the boy, the first "emission" being much more a private affair than the first "bleeding". While the adolescent girl often feels herself surrounded during this period by the interest and warmth of her parents, the adolescent boy goes through this difficult crisis unnoticed and in solitude.

The awakening of the final genital physiology is accompanied by an impulse to look for a heterosexual love object, which can only at this time be found in fantasy. This forced introversion, due to external social circumstances, is, however, responsible for part of the intensification of feelings of guilt. One cannot forget that adolescence means, psycho-dynamically, a recapitulation, a re-evaluation and a return of the early infantile conflicts and fears, which cannot become clearly conscious because of the strong barrier put up by the strict censorship of the adolescent conscience.

For the girl in particular, this discrepancy between biological and emotional maturity is a source of strong anxiety. Biologically she can now become a mother, while emotionally she has scarcely emerged from her childhood. The attitude of adults towards the adolescent girl is also highly disturbing, including the attitude of the mother, who, in one way, seems to say to her daughter, "from now on you are a woman" but who, at the same time, continues to treat her as a little girl.

Now we are approaching a problem which we believe is highly significant, from the point of view of mental health, particularly in the South American continent, that is, the age at which many women marry, and the impulse that motivates this decision other than the desirable one of establishing a home on a healthy emotional and social basis.

Indeed, in many countries, the young girl often marries years before she has reached the minimum of emotional maturity necessary to fulfil the functions of a wife and mother in such a way that they may be a source of satisfaction rather than a source of suffering and sacrifice. We often see such young wives and mothers, over-worried and anxious, or others who succumb to serious neuroses or serious mental disturbances. They cannot adopt, either towards their husband or their children, the adult and mature attitude which the function of a wife and mother, and the social status of a married woman demands.

Many different causes are responsible for this situation. But too frequently we find that the only reason is that the girl married before her complete psycho-sexual maturity and when her psycho-social personality was still in its adolescence. It is true that in many such cases, perhaps the majority, the young wife and mother does not succumb to serious neurosis. Even, however, in the absence of overt neurosis, it produces ill effects, not only on the mother, but also on her children, who cannot reach normal, healthy and desirable emotional development.

We see thousands of youngsters, the children of such homes, who never reach emotional maturity. We find in them numerous psychosomatic diseases, psychopathic characters, sexual deviations of all types, and impulsive neurosis which expresses itself in gambling, alcoholism, drug addiction and various

behaviour disorders, which find their outlet on the periphery of social life, and on the borderline of the law.

This type of behaviour, the obvious result of a personality, essentially immature, is so common in our occidental culture, that we may almost dare to say that it has become "institutionalized" as the anthropologists would say. To such a point that for many it is considered normal, and for some even acceptable.

It is far from our mind to blame such a state of affairs exclusively on the emotional immaturity of the couple at the time of their marriage. Many other factors are responsible, individual as well as social, which we cannot deal with here. We want to stress, however, that it is extremely important that this factor be pointed out, and it is the duty of the mental health worker to try to make parents and youngsters understand that it is prejudice to feel, as it is felt in so many countries, that a girl must get married as soon as she leaves college. The best mental health results obtained when young people marry after they have reached the chronological and emotional maturity necessary to make of marriage, not only a source of satisfaction and happiness for themselves, but a desirable milieu for building a home for their children, a home which will develop the necessary capacity for love, tolerance and understanding in their children and later on, be the basis for a harmonious relationship with their neighbours.

We are aware that, in spite of all that has been said in this paper, we have touched on only some of the many important points. We believe, however, that the problems presented in this paper can stimulate a discussion from which positive conclusions can be drawn. These can enable us in our practical work to strive for and maintain a high degree of mental health in our countries.

PSYCHOPATHIC PERSONALITY — A REVIEW*

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The general attitude toward the definition of psychopathic personality, which is one of vagueness, seems to reflect the old adage "I can't define an elephant but I know one when I see one." (16) This vagueness in definition naturally leads to a vagueness in diagnosis and includes within the diagnosis many varied conditions. The reason for this is probably due to the little understood etiology of this condition.

Curran, in considering twelve different definitions, found many to have the following in common; that psychopathic personality is a condition which is manifested by an episodic recurrent impulsive type of behaviour, which is socially undesirable and at present is unmodifiable, and there is no evidence of mental deficiency, psychosis, or psychoneurosis. (16)

One of the better definitions of psychopathic personality, a composite of many definitions, is that it is an illness without evidence of mental deficiency, structural disease of the brain, epilepsy, psychosis, psychoneurosis, or intellectual impairment, which manifests itself primarily in a disorder of behaviour in contradistinction to a disorder of thinking, and is evidenced by five main characteristics which are; poorly motivated antisocial behaviour, absent or weak superego or conscience, lack of sympathy with individuals and society, marked egocentricity, and at present is unmodifiable. (36, 37, 82, 119, 46, 17, 113, 66, 79, 85, 13, 73)

INCIDENCE

There appear to be no accurate statistics as to the incidence of psychopathic personality in the general population, and the only statistics at all of the incidence are few. There is also the difficulty, as stated previously, that the definition of psychopathic personality is very indefinite and varies from author to author. With these cautions in mind, the following are representative of the available statistics. (see Table 1.)

TABLE 1

Rate per 100,000			
Hall, R. W. (34)		270	
Creedmoor State Hospital (16)		2,100	(with psychosis)
Savitt, R. A. (93)		2,170	(with psychosis)
Ontario Hospitals (6)	(a)	2,700	(with and without psychosis)
	(b)	2,500	(without psychosis)
Verdun Protestant Hospital (84)	1953	4,000	(mostly with psychosis)
	1954	2,295	
	1955	2,739	
Curran, D. (16)		5,000	
Cleckley, Hervey (14)	(a)	12,833	
	(b)	26,371	
Glueck, Sheldon (29)		17,708	
Glueck, B. (28)		18,900	
Wittson, C. L. (118)		26,000	

*From Dept. of Psychiatry, University of Toronto and the Toronto Psychiatric Hospital.

TABLE 2: ONTARIO HOSPITAL STATISTICS

(Reference Number 6)

		19	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	54
First and Re-admissions	PP with Psychosis— % of total admissions		0.2	0.3	0.3	0.4	0.3	0.3	0.2	0.4	0.3	0.4	0.4	0.4	0.1	0.1	0.2	0.2	0.2
	PP without Psychosis— % of total admissions		1.3	0.9	0.3	0.5	0.4	0.3	0.3	0.5	1.1	0.8	1.3	0.9	1.7	1.7	2.4	2.5	2.5
	Total, with and without % of total admissions		1.5	1.2	0.5	0.9	0.7	0.6	0.6	0.8	1.4	1.2	1.7	1.3	1.8	1.8	2.6	2.7	3.1*

(*if including immature).

Cleckley's statistics were compiled from a Veterans Administration Hospital in the United States for the period from February 1935 to June 1937. Of a total of 837 new admissions, 102 were psychopathic personalities, 60 were chronic alcoholics, 41 were chronic alcoholics with deterioration, 14 were acute alcoholic hallucinosis, 8 were psychopathic personalities with psychotic episodes, 3 were acute alcoholics, and 8 were drug addicts. 110 of these were definitely diagnosed as psychopathic personalities (12,833/100,000) and Cleckley felt that actually 236 (26,371/100,000) were psychopathic personalities. (14)

Sheldon Glueck's statistics are derived from a study of 384 criminals, of which 68 (17,708/100,000) were psychopathic personalities. (29)

In a study of all the cases from New York City who went to all mental hospitals in New York State between 1920 and 1934, Savitt found 2.17% (2,170/100,000) had psychopathic personalities with psychotic episodes. (93)

Hall found that the admission rate per 100,000 men in the American Army Hospitals in 1938 was; constitutional psychopathic personality 270; psychoneurosis 266; dementia praecox 131. (34)

Wittson in 1942 found that of 600 consecutive neuropsychiatric cases at a United States Naval Training Centre, there were 33% mentally defectives, 26% constitutional psychopathic personality states (and inferiority) (26,000/100,000), 24% with neurological disorder, 8% with psychoneurosis, and 5% with psychosis. (118)

In the Ontario Hospital Statistics (see Table 2) it will be noted that the diagnoses are psychopathic personality with psychosis and without psychosis. They are made up to and include 1950. In 1951 the diagnosis of psychopathic personality with psychosis continued but two new diagnoses appeared in the place of psychopathic personality and disorders in personality namely pathological personality and immature personality. Only the pathological personality is included in these statistics and the immature personality is omitted as they are probably not psychopathic personalities in a strict sense, except in the last column of Table 2 in which they have been included in the total percentage (3.1%) (6).

In 1954 for example there were 5421 new and re-admissions of which 0.2% or 10 cases were diagnosed as psychopathic personality with psychosis, 2.5% (137 cases or 2,500/100,000) with psychopathic personality without psychosis, and a total of 2.7% (147 cases or 2,700/100,000) of all new and re-admissions were diagnosed as psychopathic personality with and without psychosis. If the thirty-four cases of immature personality were included in the total, the result was 3.1% (3,100/100,000) (6).

It must be remembered that many of the cases diagnosed as alcoholic or drug addiction, with or without psychosis, were probably psychopathic per-

sonalities. It must also be noted that the Ontario Hospitals are primarily for psychotic patients who are certified there, and for certain small groups of conditions coming voluntarily, and as the psychopathic personality without psychosis is not certifiable and usually does not want treatment unless in difficulty with the law, the only way these patients reach Ontario Hospitals is by being referred from the Court for mental examination or through an error in diagnosis.

The Verdun Protestant Hospital in Montreal admitted a total of 426 patients in 1953, 436 in 1954, and 438 in 1955, of which 17, 10, and 12 respectively were psychopathic personalities, mostly with psychotic behaviour. (4,000, 2,295, and 2,739 per 100,000 admissions.) (84)

Curran found that 5% (5,000/100,000) of all the cases sent to the Royal Naval Hospitals and Sick Quarters in Great Britain in 1940 with neuropsychiatric disorders had psychopathic personality. (16)

B. Glueck (1918), in a study of 608 prisoners at Sing Sing Prison found 18.9% to be psychopaths. (18,900/100,000) (28)

In no way can these statistics be considered representative of the number of psychopathic personalities in the general population.

CLASSIFICATION

The confusion which is evident in all aspects of this subject is well illustrated by the multiplicity of classifications. The following are representative.

Ben Karpman divides psychopathic personality into symptomatic or secondary psychopathic personality which he considers to be cases of neurosis or psychosis with strong antisocial or delinquent aspects, and into antheopathy (primary or idiopathic psychopathic personality) which he sees as the true constitutional psychopathic personality. (46) Partridge's classification consists of thirteen sub-groups. (80) Henderson classifies psychopathic personality as aggressive, inadequate, and creative. He cites Lawrence of Arabia and Joan of Arc as examples of the creative psychopathic personality. (36) In his classification Kraepelin divides psychopathic personality into the exciteable, the unstable, the impulsive, the eccentric, liars and swindlers, the antisocial and the quarrelsome. (57) The psychopathic personality is divided by Kahn into the nervous, the anxious, the sensitive, the compulsive, the exciteable, the hyperthymic, the depressive, the moody, the affectively cold, the weak-willed, the impulsive, the sexually perverse, the hysterical, the fantastic, cranks, and the eccentric. (44)

As can be seen by the above imposing lists, practically every known trait or condition has been included in some classification. Many, if not most, of the sub-groups in some classifications would seem to be definitely in the category of neurosis. In most instances the many sub-divisions are only characteristic of the psychopathic personality group as a whole.

It would seem that with a more limited definition of psychopathic personality the necessity to divide this condition into various sub-divisions would no longer exist. An effort in this direction has been made in the Standard Nomenclature for 1952 of the American Psychiatric Association and is listed under Personality Disorders—Sociopathic Personality Disturbances—Anti-Social Reaction which is defined as chronically antisocial, always in trouble, profiting from neither experience or punishment, maintaining no loyalties to any person, group, or code, frequently callous, hedonistic, marked emotional immaturity, lack of a sense of responsibility, lack of judgment, ability to rationalize their behaviour so it appears warranted, reasonable and justifiable. The term includes former constitutional psychopathic state and psychopathic personality. (20)

Although little is known about the etiology of psychopathic personality, it is becoming a more definite condition as more study is given to the subject.

ETIOLOGY

The etiology of this condition appears to be little understood as may be seen by the many vague and contradictory opinions. Many of the seeming contradictions are probably due to the authors using the same name while discussing different conditions. With this in mind the opinions, evidence, and theories may be broken down as follows; organic, constitutional, which includes heredity, bodily defects, autonomic imbalance, and electroencephalographic results, and thirdly, psychogenic or environmental.

Organic Factors

The evidence, opinions and theories which indicate organic pathology will be considered first. Behaviour which closely resembles certain features of psychopathic personality has been noted in some cases of head injury, Sydenham's chorea, epidemic encephalitis, general paresis, presenile or senile dementia, and idiopathic epilepsy, which indicate that any of the components of psychopathic personality can be reproduced by certain illnesses which cause pathology of the central nervous system. (36, 47, 16, 85, 48) Wiggert in 1938 demonstrated cortical changes in seventeen of fifty cases of psychopathic personality by air study. (116) Cox, Dott, and Alpers were able to show in a series of cases of tumour which destroyed the hypothalamus or interfered with its functions that certain behavioural characteristics closely resembling those of psychopathic personality were produced by these brain lesions. (15, 21, 3) Fontes feels that psychopathic personality is due to an alteration in the diencephalothalamic structures. (23) Alvez states that lesions of the diencephalon and orbital lobes are of great importance in the etiology of psychopathic personality. (4) Ingham has postulated that there is defective development in the neuronal patterns in the diencephalon so that despite good intelligence the correlate whole of behaviour is defective. (42) Heredity, diseases, and psychogenic factors may cause a failure of the long circuited response to include the diencephalon pathways so that perceptive stimuli do not pass through sufficient or proper neural circuits to have the person experience major events or issues of life as others do. (14) The following circumstances have been suggested as possibly playing a part in the etiology of psychopathic personality; mechanical birth injury, prolonged anoxia during delivery, acute infections, chronic disease and alcoholism in the mother during pregnancy. (78) The endocrine abnormalities have to be considered although there is no good evidence, but it should be noted that illnesses such as hyperthyroidism, myxoedema, eunuchism, and Cushing's syndrome can all produce personality changes. (36, 16) Solé states the cause of psychopathic personality is generally to be sought in pathological, histological, and physiologic .l changes and in heredity and constitutional factors. (106)

Constitutional Factors

The second point to be considered is the constitutional nature of this illness. The term "constitutional" is vague and has many meanings. Henderson defines it as the whole being, physical and mental, partly inborn and partly environmental. It is in a constant state of flux at all times. (36) It would appear that when most people use the term "constitutional psychopathic personality" or "constitutional psychopathic inferior" the "constitutional" means congenital or inherited. Many persons, such as North, have considered the condition constitutional or inherited because it does not respond to treatment. (78) Those who

feel this condition, or the predisposition to it, is inherited is very great, (66, 23, 54, 19, 94, 104, 105, 106, 77) but the facts are few and debatable. The citing of a family history of mental illness and instability is open to question on two counts. Firstly, many family histories quoted as being indicative of psychopathic personality are not substantially different than those of the general population, (75) and secondly, maladjusted persons tend to raise maladjusted children by giving them a poor environment. This does not prove that a genetic factor or factors is not operating; it just indicates that the evidence is far from conclusive. Slater, from his studies, feels that the predisposition to psychopathic personality is, with few exceptions, the result of the normal variation of many genes of small influence, as in normal and neurotic behaviour. (104, 105) He feels that in a few cases, specific genes may be operating. Miller, in fifty cases of psychopathic personality, has shown that the family histories of the patients do not show any more pathology than those of the general population. (75) Whelan, in a study of an aggressive psychopath whose life history markedly deviates from his uniovular twin brother, felt that the results would seem to yield evidence contradictory to the results of previous studies where hereditary factors have been considered to be of particular importance in the causation of crime. In this case environmental factors seem to be of greater importance, factors, possibly, which have had their effect in the very early years of life, but it is difficult to draw unequivocal conclusions from twin research. (115)

For many years every conceivable deformity and pathological finding were listed as concomitant of psychopathic personality. (35, 38, 90) Most authors at present hold that there are no pathological findings peculiar to this illness. (14, 12, 108)

In a study of fifty psychopathic personality patients by Rogers, 84% were found to have automatic instability by the cold pressure test, 44% had excessive sweating, and 50% had abnormal blushing. (87) Ruilmann, in a study of psychopathic personalities, felt the evidence for automatic disturbance verified that the character defect is a fundamental one, although the evidence is not too substantial. (89)

Lovett-Doust, in a study of the psychopath in prison, found evidence of constitutional immaturity as revealed by the technique of capillary microscopy, in the finding of developmental anomalies and dysplasias at the morphological level in 44% of the total number of delinquents examined, 81% of these belonging to the psychopathic group and only the remaining 19% to the controls. Capillaroscopy showed itself to be a useful ancillary diagnostic procedure, 66% of the subjects sampled being classified in agreement with clinical examination by this means alone. (64)

Most electroencephalographers who have done extensive studies on psychopathic personalities have found a greater percentage of abnormal electroencephalograms than in the general population. This is best seen in a review by Silverman of the findings of six different investigators who considered 694 psychopathic personality states in which 336 or 48.4% had abnormal electroencephalograms. (100) The findings are most often 4-7/second slow waves, bilaterally, with maximal amplitude over the anterior scalp and/or temporal region. (100, 96) Abnormal findings are more often found in the aggressive psychopathic personality than in the inadequate passive psychopathic personality. (39, 58, 74, 100, 107) Simons disagrees with these results and finds no greater percentage among psychopathic personalities than in the general population, but his definition of psychopathic personality differs from the other investigators and is much broader. (103)

Knott and Gottleib found that an abnormal electroencephalogram is more often found in the psychopathic personality with a positive family history of mental illness, epilepsy, and/or instability than in those without. (52) They also found that there were more abnormal electroencephalograms in psychopathic personalities with a history of severe illnesses or head injury with unconsciousness than in those without. (31) In a study of 95 cases and their parents, by Knott, 30.2% of the true parents had abnormal slow waves. There was a tendency for patients with slow electroencephalographic wave pattern to have parents with slow wave patterns and fast with fast. (53)

An abnormal electroencephalogram is not pathonomic of psychopathic personality and the electroencephalographic results may be divided into psychopathic personalities with normal electroencephalograms and psychopathic personalities with abnormal electroencephalograms which are genetic in origin or due to cortical damage sustained early in life through illness or injury. (52) The abnormal electroencephalographic patterns may be explained as being hereditarily determined (32, 58, 94) or due to an early acquired cerebral dysfunction or an indication or result of the individual's adjustment to his environment (86) or a combination of any of these. The abnormal electroencephalographic patterns would be considered normal if they were found in a child. Because of this, some authorities (99) suggest the abnormal electroencephalograms in psychopathic personality are indicative of a general immaturity. If the electroencephalograms are arranged by age it will be noted that the number of abnormal electroencephalograms decreases as the age increases, so there is a possibility that the psychopathic personality may grow out of his illness. (99) There is some evidence that many psychopathic personalities, by the age of forty and up, settle down and become reasonable citizens (36, 84) and certain cases have been followed electroencephalographically and a concommitant maturation has occurred in the electroencephalogram with the clinical improvement. (96) Some explain this by saying that the improvement in the clinical condition by age forty is due to the decrease of libido. (27)

The results of the electroencephalogram were thought to indicate to some persons that psychopathic personality is related to epilepsy, but this has not been substantiated. (52) It is felt rather that the electroencephalogram may possibly indicate neutral limits which are less elastic and make the individual more susceptible to difficulties in social adaptation. (52, 100)

Environmental Factors

The psychological or environmental etiology theories divide themselves roughly into three groups, those which actually consider psychopathic personality in the class of neurosis by implicating neurotic mechanisms, those which implicate an earlier stage in development where the neurotic mechanisms have not yet come into action, and those which fall between the above two opinions.

The advocates of the first group are those who tend to support the acting out theory (2, 56, 79) which says that while in neurosis the anxiety produced by unresolved forbidden instinctual strivings is dealt with by the development of neurotic traits, that with psychopathic personality the individual is handling the anxiety produced by these unresolved conflicts by using the defence of acting out his feelings of aggression and getting gratification by the mechanism of substitution and displacement. (2) Miller feels many so-called psychopathic personalities who have evidence of guilt are severe character disorders with neurotic acting out as a defence against anxiety, which may come from a pathological family constellation or from unresolved oedipal triangle and is controlled by aggressiveness against parental authority or society. The identification with an un-

wholesome parental figure may also play a part. The antisocial criminal behaviour is an effort to re-enact an earlier emotional experience in which the person's mother gave him attention. It may also be an attempt to ward off castration anxiety by pseudo-aggression. Miller feels that most of these would fit into other groups rather than psychopathic personality if they were adequately explored. (75)

This type of approach is demonstrated by the following investigations. Solomon, in a study of 1400 male psychopathic personalities in the United States Army, did a detailed study of 50 cases of this group randomly sampled which he felt were representative and indicative of the group as a whole, found all the cases had poor family relationships with resultant development of a faulty super ego, disturbed male-female identification, and particularly unwholesome identification with father figures and so related poorly to authority. There is complete arrest of psychosexual development in the latency period when libidinal ties are weak with parental figures and homosexual feelings are strong. There is an attempt to resolve oedipal ties but due to a lack of adequate parental symbols with which to identify there is an acting out of aggression. (108) (See Table 3). Knight has demonstrated in the case histories of many alcoholic psychopathic personalities the existence of inconsistent parental background with lack of parental agreement, with a weak pampering mother and an inconsistent domineering father with resultant oral fixations. (50,51) Greenacre feels that she has been able to demonstrate in many psychopathic personalities a strong authoritarian father and an indulgent, frivolous mother. (33) Fenichel calls it an impulsive neurosis with predominantly oral fixation with the formulation "I will give him nothing because nobody gave me anything." (22)

TABLE 3

(Reference Number 108)

	Number of cases	Percentage
Nervous or ineffectual mother	17	34
Nervous or ineffectual father	13	26
Alcoholic father	12	24
Divorced or separated before 12	9	18
Death of father before 12	9	18
Rejecting mother	8	16
Punishing father or step-father	5	10
Death of father after 12	5	10
Punishing mother or step-mother	4	8
Death of mother before 12	4	8
Desertion of father before 12	2	4
Death of mother after 12	2	4
Divorced or separated after 12	1	2
Abandoned by mother	0	0

Total number of cases 50

The second group implicate the theory of maternal deprivation as the main factor in the etiology of psychopathic personality. (7, 9, 109, 83) This view is exemplified by the work of the following persons. Rabinovitch states that the development of psychopathic personality in children results from severe emotional deprivation in the infantile period without affectional ties or essential physiological stimulation necessary for the normal personality growth. (83) Lowrey, in a study of institutionalized infants, states, "Infants reared in institutions undergo an isolation type of experience, with resulting isolation-type of personality, characterized by unsocial behaviour, hostile aggression, lack of patterns of giving and receiving affection, inability to understand and accept limitations, and marked insecurity in adapting to the environment." (65)

Lauretta Bender is in agreement with the idea of maternal deprivation and has stated in an effort to explain the lack of anxiety and guilt in these persons that anxiety and guilt are not primarily instinctive qualities but arise in reaction to threats to object relationships and identification. As it is the ability to form object relationships and identifications which the psychopathic personality lacks, there is little cause for anxiety or guilt. (7) A poorly defined ego concept and no superego awareness are also the result of this severe early deprivation. Because of this the patient develops social agnosia, which is the inability to identify with social concepts and problems. (83)

The critical age in child-parent relationships is less than two years of age although the third and fourth years are of importance. (83, 9) Spitz is also in agreement with this and in a study of 366 children noted that there was a tendency to have inconsistent mothers who rapidly changed their attitudes and who have an infantile and psychopathic personality so that the child in the first years of life is confronted with an unpredictable love object. (109)

Wittels feels the psychopathic personality is arrested at Jones "protophallic" phase because the meaning of parental authority is not known and there is no particular respect for the mother. This is before the oedipal conflict has arisen, consequently there has been no development of super-ego or castration fears. (117)

Cleckley, in an effort to explain why some psychopathic personalities come from what appears to be an adequate home, states it often can be demonstrated that the parents are lacking in simple warmth and a capacity for true intimacy which is subtle and hard to elicit. (14)

Lippman and others have also mentioned that excessive indulgence can have the same results as deprivation because as every whim is satisfied there is inadequate stimulus for the production of a superego and the appreciation of others' feelings and actions. (62)

Thirdly, many persons advance hypotheses between these two positions and point out the poor family environment. Rogers, in a study of 50 psychopathic personalities, shows 16% came from unbroken homes and normal backgrounds, 60% from broken homes, 14% from over-protected homes, and 70% from a rejecting environment. (87) Silverman, in a study of 75 psychopathic personalities, found 80% had an unhealthy parent-child relationship. (100)

In relation to the evidence of disturbed parent-child relationships, it must be remembered that this may not be entirely due to an unhealthy attitude in the parents but could possibly be attributed to the fact that the child is handicapped in his development of adequate interpersonal relationships due to adverse heredity and because of his inability to respond adequately to his parents, he engenders hostility and aggression in them.

From this discussion on the etiology of the psychopathic personality it would

appear that the most reasonable point of view at the present time is to regard the condition as the result of certain inherited potentialities in the individual which interact with an adverse environment, for example infantile maternal deprivation, to produce the psychopathic personality.

DIAGNOSIS

The best description of psychopathic personality, using the definition stated previously, is by Cleckley in which he lists sixteen characteristics. He describes the psychopathic personality as one with a degree of superficial charm and good intelligence as measured by psychological tests. There is an absence of delusions, hallucinations or other signs of thought disorder indicative of a psychosis; and usually an absence of nervousness or psychoneurotic manifestations. There is an immunity from guilt or worry although they may be vexed and restless in jail or hospital and provoked by external situations, but not through a sense of guilt, remorse or interpersonal insecurity. They are unreliable, untruthful, and insincere, but may work well for short periods, (which is difficult to understand and explain). There is a lack of remorse or shame and a denial of responsibility for their actions and a tendency to blame others. Inadequately motivated antisocial behaviour is prominent in the psychopathic personality with demonstration of poor insight and judgment as shown by their actions, although they can express excellent theoretical and verbal insight and judgment. Their behaviour is not significantly modified by experience or punishment. They have a pathological egocentricity with an incapacity for true love or deep friendship and do not seem to experience true deep emotions as others do. There is a lack of appreciation of the feelings of others, as demonstrated by their callousness, although they can perfect or imitate the outward social graces. The psychopathic personality may often demonstrate rather bizarre behaviour with and without alcohol and may frequently try ineffectual suicide in a histrionic manner. Their sex life is impersonal, trivial, and poorly integrated, and although their impulses are not of a strong nature, their inhibitions are weak and so gain expression with little restraint. A failure to follow a life plan or persist toward definite goals is evident. The psychopathic personality tends to mimic the emotional response of others to life's situations. (14)

To substantiate Cleckley's description in part, the following evidence is presented. (See Table 4) Mueller took 100 psychopathic personalities and compared them with 100 each of the following; psychoneurotics, well-adjusted persons, World War 2 psychotics, World War 1 psychotics, and 100 alcoholics, against certain situations or characteristics found in their histories as listed in the first column of Table 4. The numbers marked by asterisks(*) indicate which of 6 listed groups of patients has the greatest number of persons to the item listed in the left hand column. The importance of early home life is shown by the high incidence of broken homes. The sulkiness under discipline, difficulty with teachers, chronic truancy, and arrests are indicative of the difficulty with authority, and their anti-social traits. The turning to themselves as a source of satisfaction is demonstrated by thumb-sucking. The high incidence of nail-biting and temper tantrums indicates a means of expressing aggression. Tantrums, nail-biting and obsessional traits are supposed to be indicative of inverted or sublimated aggression which by the classical analytic explanation would require some development of the superego which the psychopathic personality is said to be lacking. (76)

Cason, (1946-48) in a study of 500 successive admissions to the psychopathic unit at the Medical Centre for Federal Prisoners at Springfield, Missouri, found that the psychopath was young: 73% were under 30 years of age and only 1%

TABLE 4

(Reference Number 76)

	N 100	WA 100	WW2P 100	WW1P 100	A 100	PP 100
Broken Homes	38	18	40	49	49	61*
Sulkiness Under Discipline	34	6	39	31	43	89*
Difficulty with Teachers	28	10	28	32	31	43*
Chronic Truancy	24	4	21	33	24	40*
Arrests	20	12	21	19	42	52*
Tantrums in Childhood	16	8	19	19	18	46*
Thumb-Sucking or Nail-Biting after 6	32	4	28	15	19	41*
Obsessional Traits	36	6	41	47	39	49*
Alcoholism	10	4	14	19	100*	49
Repeated Grades	68*	20	61	64	54	51
Fail to Join Competitive Sports	34	4	42	51*	49	31
Abnormal Attachment to Mother After Puberty	52	10	58	53	81*	7
Preference to play alone	30	6	46	49*	36	5
Shunning girls after puberty	20	10	21	17	62*	8
Abnormally shy and sensitive	36	2	42	39	46*	2
Abnormal Fears	38	6	67*	52	48	8
Faints	34*	2	23	29	16	6
Bed wetting after 4	32*	4	28	17	5	11
Stammering	16*	6	14	10	7	6
Excessive Autonomic Reaction to Emotion	56	4	69	61	89*	9
Previous Mental Illness	4	0	9	12*	5	4
Psychosis in Family	14	4	23	31*	11	6

N —Psychoneurosis
WA —Well Adjusted
WW2P —World War 2 Psychosis
WW1P —World War 1 Psychosis
A —Alcoholic
PP —Psychopathic Personality

over fifty. He tends to be white, of native birth, and either not married or living in a common-law relationship, separated or divorced. Educationally psychopaths are well below average and they tend to be employed in unskilled or illegal occupations. The usual offence is stealing cars. Psychopaths usually have a long delinquent record since they serve heavy sentences. 81% were known recividists. Only 35% came from a home that was not broken before the age of eighteen. Intelligence of the group was normally distributed. (12)

Stafford-Clark, Pond, and Lovett Doust, from a study of male psychopaths in prison, attempted to predict accurately whether a particular subject would be found in the psychopathic group or the control group by the use of the clinical approach (See Table 5) (110)

TABLE 5

(Reference Number 110)

Heading of Inquiry	Tendency Displayed by Psychopaths	Reliability as a method of Predicting Division Between Psychopaths and Controls on This Basis Alone	Level of Significance
			Per Cent
Response to punishment	Rejection or failure to respond	89.3	1
Response to appeals	Rejection or failure to respond	86.7	1
Goals	Goals undefined or abandoned	66.2	1
Plans	None made or none followed consistently	68.9	1
Developmental attitudes	Rebellion and resentment leading to rupture with parents at adolescence	81.6	1
Early relationships with parents	Resentment and hostility towards father	68.2	1
School career	Expulsion, frequent changes or truancy	67.5	1
Adjustment in society	Recidivism and repeated convictions. (Average number of convictions of all psychopaths was 7.4 and of all controls 3.0)	76.8	1
Job record	Average period in job less than six months throughout total work period	72.2	1

Ripley and Wolf in a study of 50 psychopathic personalities with psychosis in the United States Army found the following significant in the history; the family settings were insecure, there was often a history of eneuresis, nail-biting, temper-tantrums, and sleep walking. Scholastic performance and school adjustment was poor, the work record showed frequent job changes, periods of unemployment and difficulty getting on with the bosses and workers, two-thirds of them had been arrested one to thirty times, they showed poor marital adjustment and sexual promiscuity, twenty-two were alcoholics, ten had attempted suicide, six were homosexual, five were drug addicts, and many showed previous neurotic and psychotic illnesses. (86)

B. Glueck (1918) in a study of 608 prisoners at Sing Sing Prison found a marked tendency in psychopathic prisoners to habituation to alcohol, drugs, and excessive gambling. Of the 114 psychopaths, 85% exhibited psychopathic behaviour in early life, 75% had serious difficulty with school, and the occupational histories were irregular and inefficient. (28)

Solomon showed from the histories of 50 cases of psychopathic personality the high incidence of aggressiveness during childhood. (108) (Table 6).

The psychotic patient differs from the psychopathic personality by the presence of the classical signs of psychoses as delusions, hallucinations, etc. (14)

TABLE 6

(Reference Number 108)

Diagnosis	Aggressive During Childhood		Nervous During Childhood	
	No.	Percent	No.	Percent
Emotional Instability*	13	61.9	7	24.1
Inadequate Personality	0	0	14	48.3
Emotional Instability—Chronic Alcoholism	2	9.5	4	13.8
Asocial Trends	3	14.5	3	10.3
Aggressive Reactions	1	4.7	0	0
Emotional Instability—Drug Addiction	1	4.7	0	0
Alcohol Addiction	1	4.7	1	3.4
TOTAL	21	100%	29	100%

*Emotional Instability = Psychopathic Personality

The diagnosis of pyschosis with psychopathic personality is a frequent diagnosis but Karpman reviewed 24 cases of psychosis with psychopathic personality and found only 4 of them to be true psychopathic personalities, and only 5 true psychotics, and found many of the others were either neurotics or hysterics. (45) Ripley and Wolf report a study of 50 psychopathic personalities with psychosis which developed in very inelastic situations in the South Pacific where the facilities for the expression of instinctual needs were few and they compare this with the psychosis which occurs in some psychopathic personalities when confined to jail or hospital. (86) (22) Patients with this diagnosis may clear up rapidly once confinement is ended. It will be noted this is two diagnoses, not one—psychosis and psychopathic personality. (14, 19)

In relation to the schizoid individual, the psychopathic personality is not shy, retiring, or ingoing. (14)

In relation to the patient who is paranoid, the psychopathic personality may have ideas of persecution and injustice but these are not organized and do not influence behaviour so that it is persistently directed toward the alleviation of the supposed persecution as a paranoid would. (14)

The psychopathic personality differs from a psychoneurotic patient in that he has a surprising lack of anxiety and guilt, tends to be free of neurotic symptoms and acts out his feelings whereas the psychoneurotic develops neurotic traits. To argue that psychopathic personality is a neurosis because it is a disorder in which emotional factors have etiological significance is valid as long as one calls schizophrenia and paranoia a neurosis. (14)

As compared with the mentally defective, the psychopathic personality usually has a normal intelligence quotient. (14)

In relation to the ordinary criminal, who acts in a purposeful although antisocial manner and who persists towards his goals which the psychopathic personality does not, the criminals ends are understandable but the psychopathic personality's are not, and criminals tend to spare themselves and hurt others while the psychopathic personality seems to hurt himself most, but also others. The psychopathic personality seldom is involved in major crimes and often makes little

or no attempt at concealment. They are not whole hearted in wrath or weakness. Most of what has been said above about the ordinary criminal may be said of those patients with behaviour disorders who use neurotic mechanisms in an effort to resolve their conflicts, distinguishing them from psychopathic personalities. (14)

The psychopathic personality is differentiated from the homosexual and the sexual deviate in that, with his poor inhibitions, he tends to involve himself in any sexual practice at any time the impulse occurs to him, but rarely pursues one sort of perversion exclusively. He should be considered a separate entity from the sexual psychopath, who is usually not a psychopathic personality but a neurotic or a psychotic. (14, 45)

In relation to the erratic man of genius, the psychopathic personality is not consistent or persistent in attaining a goal. (14)

The alcoholic drinks to escape an emotional problem, often has insight, the desire to be cured, and his behaviour is usually understandable, but none of these apply to the psychopathic personality who may drink to excess because of his poor inhibitions. (14)

In contrast to the malingerer who at least persists in the goal of avoiding something, for example work, the psychopathic personality does not persist in anything. (14)

In contrast to the masochist, the psychopathic personality resents any form of punishment and has a very strong aversion to any kind of confinement in prison or hospital. (19)

At times it is difficult to make a sharp distinction between the psychopathic personality and the above conditions. It must be stated that any of the characteristics listed for psychopathic personality are also found in other illnesses and no one characteristic is pathonomonic of psychopathic personality except possibly the absence of conscience or superego, and that there are all degrees of psychopathic personality.

Kirkwood states that much caution must be used in using the diagnostic category "sociopathic personality disturbance" (psychopathic personality) with juvenile offenders as most juvenile offenders do not have a sufficiently lengthy history to justify this diagnosis. (49)

The characteristics of the psychopathic personality may be explained by using abstractions of the individuals make-up which have only didactic usefulness but no existence as such in reality. (See Table 7) The importance of the dysfunction in affectivity in the psychopathic personality may be seen as the prevailing mood is known, to color the manner of all experience. A degree of affective consistency is necessary because otherwise unpredictable fluctuating attitudes develop as in the psychopathic personality who is unable to experience and appreciate any deep or lasting emotions. Because of this emotional shallowness and inconsistency of mood, the psychopathic personality is unable to profit from experience or punishment as these leave no lasting impression, he is unreliable and unpredictable, and he is unable to love or form deep friendships as the emotional bond is only superficial. (24, 72)

Conation is defined as the motivational force which directs and impels striving and efforts. It is synonymous with will, instincts, impulses, libido, or id. The dysfunction in conation is evidenced in psychopathic personality by the inability to preserve in tasks and to follow a life goal. (24, 72)

Empathy may be defined as the feeling into, or the projection of one's consciousness into another being. Empathy is a prerequisite for love, friendship, and social interest. Without it, the ability to learn social values is superficial.

TABLE 7

Reference Numbers 24, 72, 56, 83, 46, 108, 7, 60, 61, 85, 117, 97, 26)

Dysfunctions in				
Affectivity	Conation	Empathy	Superego	Ego
unpredictable	perseverence poor	lack of remorse	lack remorse	lack remorse
fluctuating attitudes	to follow life goal, poor	lack of shame	lack shame	lack shame
inconsistency of mood		human relationships poor	anti-social behaviour	anti-social behaviour
unreliable		callous	to follow life goal, poor	human relationships poor
doesn't profit from experience		poor sex life	poor judgment	poor sex life
human relationships, poor		unreliable		untruthful
		untruthful		insincere
		insincere		

The poor capacity to empathize as seen in the psychopathic personality is in part responsible for the psychopathic personality's relative absence of anxiety, guilt or conflict. Anxiety, guilt and conflict depend on the person's ability to identify with humans and objects and arises from a threat to these. The psychopathic personality is unable to identify well and it is from the ability to identify that empathy arises. Due to this defect the psychopathic personality will show lack of remorse or shame, incapacity for deep human relationships, lack of insight, callousness, poor sexual life, unreliability, untruthfulness, and insincerity. (24)

There is also a dysfunction in the superego, (108, 7, 60, 61, 85 117, 56, 83, 46) the superego being defined as the incorporation within an individual of social mores as reflected by the parents or parent surrogates and also the incorporation of an ego-ideal. Due to the poor development or lack of superego, the psychopathic personality shows a lack of shame or remorse, inadequately motivated anti-social behaviour, failure to follow any life plan, and often poor judgment due to lack of an ego-ideal. The unreliabilty, untruthfulness, and the insincerity can also be explained by the lack of superego and because of this, weak or infantile drives can gain expression in a theatrical manner without inhibition. Shtoffer-Tenenblatt cites the detailed psychodynamics of a case of antheopathy (psychopathic personality) who was without a superego, the id reigning supreme and without the need for the development of an ego, who had no definite personality but changed it as the mood struck him. (97)

The ego is that part of the personality which tests reality and functions in the integrative, adaptive, and executive spheres. The dysfunction of the ego in the psychopathic personality is evidenced by pathological egocentricity or self-centredness, which accounts in part for the lack of remorse or shame, the inadequately motivated anti-social behaviour, incapacity for love and deep human relationships, impersonal, trivial and poorly integrated sexual life, and the lack of truthfulness and sincerity. (83, 7, 60, 61, 26, 56, 46)

TABLE 8

Reference No. 11

Ego-centric personality	Deviations in			The following types of behavior or conditions.
	Feeling	Thinking	Acting	
	hedonism	lack of a sense of responsibility	frequent change	nomadism
	emotional immaturity	lack of judgment	social delinquency	alcoholism
	callousness	inconsistent worry	sexual delinquency	homosexuality
	hairtrigger emotions	rationalization	drug addiction	criminalism
				neurosis-psychosis

The artificial nature of these categories is evident and many of the characteristics can be explained by more than one dysfunction. These dysfunctions and most of the characteristics of psychopathic personality can be explained by maternal deprivation in the widest sense, occurring in an individual predisposed by his hereditary endowment in the following manner; maternal deprivation causes inadequate development of human identification and object relationships which leads to poor capacity for empathy, poorly defined ego-concept, and poorly developed superego, and these in turn can lead to the characteristics of psychopathic personality as listed previously.

Another descriptive approach is to consider the defects in the make-up of the psychopathic personality in the sphere of feeling, thinking and acting. (11) (See Table 8)

In considering the diagnosis of psychopathic personality, Glover made two very pertinent points. These were that when a disordered state can be better placed in another category it should not be included under the diagnostic or psychopathic personality, and when during a remission the ego is found to be normal, the state is not psychopathic personality. (27)

Psychological tests have been used in an effort to aid in the diagnosis of psychopathic personality but with the tests used routinely at present a diagnosis of psychopathic personality cannot be more than hinted at. A specially devised multiple-choice test and a sentence-completion test were tried on 22 psychopathic girls with the underlying concept that, although the psychopathic personality is capable of learning social values, it is unable to utilize these values when a conflict arises between primitive needs and social goals. The multiple-choice test was found to be of no use as it presented obvious comparisons but the sentence-completion test was found to be of value in the diagnosis of pyschopathic personality as it forced the patients to use their own value systems without obvious clues or comparisons. (102)

Holzberg found that the Rosenweig Picture Frustration Study was not capable of discriminating between socially aggressive adolescent psychopaths and socially non-aggressive normals. (41)

Solomon, from his study of psychopathic personalities in the United States Army found, that the Rorschach Test shows a picture of aggressive or passive introversion with an emotional tone of anger or fear; also impulsively and sensitivity to slight external pressures, particularly aggression, with little range of interest and little digression from their own central theme. There are elements of perversity and suspiciousness. Intellectual capacities give them little protection from stresses because their emotional instability lowers their mechanisms of control, hence they act without the exercise of good judgment. (108)

Through the use of a series of perceptual-cognitive tasks on forty-one psychopathic delinquent boys and forty-nine controls, Sarbin and Jones have been able to differentiate the psychopathic delinquent from the non-delinquents. The results of their investigation offer tentative support to the general hypothesis that the psychopathic delinquent's self-structure is different from that of his non-delinquent peer and that this difference is most readily seen as a retardation in perceptual, cognitive functioning. (91)

The diagnosis of this condition is often in doubt and is difficult to make because superficially the personality appears to be intact and it is necessary to rely on the past history, which is often unavailable, incomplete, or doubtful. It will probably continue to remain so until better methods of psychological testing are found to diagnose the psychopathic personality and until a more accurate definition and adequate understanding of the etiology are attained.

TREATMENT

On the subject of treatment, accurate information is scarce but may be divided as follows; psychotherapy, physical methods, which includes electroconvulsive therapy, leucotomy, drugs, and insulin, and therapeutic community.

Under psychotherapy, the following is of interest. Hinsie, in 1938, reported on 23 cases at the Berlin Psychoanalytic Institute during a ten year period. Of these, 18 discontinued treatment, 4 were unimproved, and 1 recovered or was much improved. (40) Henderson suggests personal understanding, training, and control and management of the environment. (36) Woolley (1942) stated that an adequate training program was necessary with consistent non-punitive discipline, which would constantly deprive the psychopathic personality of success in his abnormal behaviour and one which would force him to face the consequences of his actions. (119) Aichorn felt that the treatment of the younger psychopathic personality should be carried on in an institutional setting with consistent tolerant acceptance regardless of his behaviour. (1) It is Cleckley's opinion that certification to an institution is necessary where the psychopathic personality can be effectively controlled with a well supervised parole system and gradual rehabilitation. (14) Mangun reports some encouraging results in psychopathic personalities who were treated in institutions with consistent non-punitive therapeutic discipline and psychotherapy. (67) Anderson claims some favourable results in controlled settings over a long period of time. (5) Levine feels that some forms of psychotherapy may be of real help in milder cases of psychopathic personality. (59) Schilder maintains that psychotherapy should be tried using the same principles as in neurosis with special attention to overcoming the patient's resistance. (95) Curran suggests obligatory rehabilitation under discipline and psychiatric supervision for severe psychopaths, and for the more transient ones simple methods of psychological and environmental management are suggested as they attain reasonably good results. (16) In the treatment of the psychopathic personality the physician must take care not to reflect society's unfavourable attitude toward the psychopathic personality so that he may develop empathic

feelings for the motivational forces within the patient. (10) Bromberg also states that it is necessary to dissolve the patient's character defences by group psychotherapy with the use of a play technique and psychodrama, so that the psychopathic personality can objectify its interemotional problem. (10) Bennett makes a plea for the principle of suspended or indefinite sentence for the psychopathic personality in a non-penal institution as established in Denmark where the psychopathic personality knows his privileges and that his release depends solely on his behaviour. (8) Newkirk shares this opinion and states that the psychopathic personality is difficult to treat and should be segregated for an indefinitive period of time. (77)

Due to the psychopathic personality's difficulty with identification and empathy, he is usually unable to form transference and so it is difficult to do much psychotherapeutically as it is impossible to awaken an affectional relationship to a previously existed parent. (1, 7, 22, 46)

In considering the use of physical methods in the treatment of psychopathic personality the following information is of note. Darling (1945) in an article reports on the use of electrocoma therapy in the treatment of 3 cases of psychopathic personality. The first case showed no improvement, the second case was a manic-depressive and pyschopathic personality; the psychopathic personality cleared but the manic-depressive illness persisted, and the third case was well-adjusted at a six months follow-up. (17) Strecker suggests the use of electroconvulsive therapy but does not mention any results. (111)

Sargent and Slater suggest the use of amphetamine in the treatment of the aggressive psychopathic personality, and the use of stilboesterol if the patient's libido is increased. (92) I have been unable to find any information on the value of chloropromazine, frenquel, reserpine, equanol, barbiturates and insulin in the treatment of psychopathic personality.

Darling (1952) reported on two series of cases of patients who had received transorbital lobotomies to manage their particularly aggressive and difficult psychopathic personality behaviour. In a one year follow-up of 12 cases, all but one had improved, and in the second series, which included the above 12 cases plus 6 others, more than half were socially adjusted outside hospital. (He states that many people consider this condition due to a deficiency, which it cannot be if the patient improves with a leucotomy. (19) Tancredi reports on 12 cases of psychopaths who received prefontal leucotomy, in which only 2 benefited (1 explosive and 1 paranoiac). (112) Kolb states that a few lobotomies have been done on criminal psychopathic personalities and that their violent and destructive behaviour was relieved and they were easily handled, but recovery and discharge were infrequent. (55)

Maxwell Jones has conducted an experiment for seven years in what he calls a therapeutic community in the one hundred bed Social Rehabilitation Unit of the Belmont Hospital in England. The aim of the experiment was to subject the antisocial individual to a socializing experience which might lead to some modification of his behaviour. The community was arranged in such a manner as to study and modify its own tensions, values, aims, and social organization in a non-punitive manner. The patients met with the staff and amongst themselves to freely discuss their problems daily. Most hospitals expect the patient to accept the role assigned to him of childish dependency upon the hospital, which this experiment attempted to avoid. In 1952 Jones, in a careful follow-up study, found changes in social attitudes and values and the development of more constructive behaviour and some guilt feelings in many of the patients. (43)

Gibbens, in a very interesting article, compares the laws and the institutional

care and treatment of psychopathic offenders in Denmark, Sweden, United States, and England. No statistics as to their results of treatment are given, and much of the discussion is about the "sexual psychopath". (25)

PROGNOSIS

The prognosis of this condition is generally conceded to be poor although certain authors as Aichorn, Woolley, Mangun, and Maxwell Jones claim some good results in institutional settings where the patient is made to face the consequence of his actions in a non-punitive atmosphere. (1, 119, 67, 43) Glover does not share the general tendency to form a pessimistic prognosis for psychopathic states which frequently resolve spontaneously in middle age. He feels that a sufficiently elastic application of psychoanalytic principles could provide a suitable therapeutic method applicable to both individual and social aspects of the problem and produce almost as favourable results as those obtained in the case of the psychoneurotic delinquent. (26)

Powdermaker, in a study of the therapeutic responses of delinquent girls with varying early family experiences showed the following; (see Table 9) (81)

TABLE 9

(Reference Number 81)

Early Family Experience	Effects of Therapy	
	Success	Failure
No rejection and some constructive family tie present	25	0
Rejection by some member of the family but some constructive tie present also	12	10
Neurotic and ambivalent relationship	3	13
Complete rejection and no libidinal tie	0	17
TOTALS	40	40

The prognosis therefore would seem to possibly vary with the degree of rejection in early life, although the only group of girls who are true psychopathic personalities in the above table is the one with complete rejection and no libidinal tie.

Torma in a follow-up of 30 children diagnosed as psychopaths at the ages of 2 to 14 and at the time of the follow-up were all over 18 years of age, found 21 had made a satisfactory adaption and 9 had difficulties in adjustment. Therefore he states care must be taken in making the diagnosis of psychopathic personality in childhood as environmental influences are of decisive significance. (114)

The prognosis is made poor by the fact that most psychopathic personalities do not want treatment unless they are in trouble with the law; they have poor insight into their condition; they lack perseverance, and are unable to identify and empathize well and so transference in the psychotherapeutic setting is impossible. (14, 24, 1, 7, 22, 46,)

PREVENTIONS AND SUGGESTIONS

At present, as the treatment results are poor, the avenue of approach left open is prevention.

Every effort should be made to prevent maternal deprivation of the child, particularly in the first few years of life. This is well stated in Bowlby's "World Health Monograph of Maternal Care and Mental Health" in which he emphasizes

that every effort should be made to avoid long periods of institutional care in the first few years of life, particularly under the age of two, by earlier and better foster home placement and adoption. (9, 83)

Improvement of social measures is suggested by Henderson, for example more and better social service, child-guidance clinics, child-welfare centres, children's courts, and better probationary systems, approved schools, Borstal institutions, and better medical education. (36, 37)

Some provision should be made for the care of children of obviously psychopathic parents as psychopathic parents tend to raise psychopathic children.

Better organized and more extensive research into the cause and possible methods of treatment of this condition should be undertaken, but this would require institutions to confine these patients for an indefinite period of time and some legal method of commitment to these institutions. (14)

It is important that this condition be recognized early so that treatment may be attempted as soon as possible. (22, 84) This would require a better understanding of the diagnosis of this condition by the medical profession and a concise and precise definition of psychopathic personality.

Cleckley advocates that these patients should be certifiable and sent to appropriate institutions which would have to be constructed as the present system is incapable of adequately looking after these persons. He felt that a change was necessary in much of the present medico-legal attitude toward this condition. Two main problems have to be settled; the question of distinguishing between illness as a true disability and wilful or culpable misbehaviour and the question of legal responsibility and competency. To answer these questions, a change is needed in the present concept of sanity, for example, that an individual is either responsible or totally irresponsible due to insanity, and it should be admitted there are all degrees of responsibility. On the question of certification, Cleckley states the question should not be asked "Is this man responsible?" but "Of what is he capable or incapable?" He also feels a change is necessary in the underlying assumptions of faculty psychology with which the M'Naghten rules are formulated, for example the faculty of reason is the test of sanity while the person's actions are given little consideration. In assessing a person's sanity, the test at present is restricted to peripheral manifestations as delusions and hallucinations but ignore the deeper seated and masked pathology. The intrusion of basic personal convictions in problems of criminal responsibility should be avoided, for example argument about free-will and other philosophical problems. (14)

Cleckley feels any psychopathic personality who commits anti-social actions should be given an indeterminate sentence or committed under psychiatric care until he is capable of successfully re-entering society and that there should be legal facilities for the placing of psychopathic personalities under medical care whether or not they have committed illegal acts. (14)

All behaviour, normal or abnormal, is a process of adaptation between physiological needs and external circumstances. (75) With this in mind, it will be anticipated that as the structure of community living becomes more complex, and as more laws and regulations are made with the assumption of producing a more conforming attitude in each individual, the number of those unable to subscribe to the spirit of these laws is likely to increase (47, 48) and will bring to light the latent or somewhat adjusted psychopathic personality.

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Résumé

L'une des meilleures définitions d'une personnalité psychopathique est la suivante: une maladie sans évidence de débilité mentale, de lésion structurale du cerveau, d'épilepsie, de psychose, de psychonévrose, ou de déficience intellectuelle, qui est caractérisée principalement par un trouble de la conduite par opposition à un trouble de la pensée, et qui se présente sous cinq caractéristiques principales: un comportement anti-social pauvrement motivé, un surmoi ou conscience absent ou faible, absence d'"empathie" à l'égard des individus et de la société, égocentrisme marqué, et incurabilité jusqu'à maintenant.

Il ne semble pas exister de statistique précise sur la fréquence de cette entité dans la population générale. Quelques-unes des statistiques existantes apparaissent au tableau 1 du texte anglais. Les taux sont donnés par cent mille de population.

La confusion dans tous les aspects de cette entité est bien mise en évidence par la multitude des classifications. Il semblerait qu'avec une définition plus précise de la personnalité psychopathique, il n'y aurait plus nécessité de la subdiviser en de si nombreuses variétés.

Son étiologie apparaît peu connue en face des opinions nombreuses, vagues et contradictoires. Tous les symptômes de cette maladie peuvent être produits par des atteintes lésionnelles du système nerveux central, comme par exemple, les traumatismes crâniens, l'encéphalite épidémique et la démence sénile. Plusieurs estiment héréditaire cette condition ou la prédisposition à cette maladie;

cependant, les preuves sont rares et contestables. La plupart des auteurs estiment qu'il n'y a pas de changements neuropathologiques spécifiques à cette maladie.

Certains auteurs, par leurs études, sont d'avis qu'il existe des déficiences constitutionnelles chez les personalités psychopathiques, mises en évidence par l'instabilité du système autonome, des anomalies de développement et des dysplasies des capillaires, et par la découverte de tracés électroencéphalographiques anormaux en plus grand nombre que dans la population générale. Ces anomalies électroencéphalographiques sont constituées le plus souvent par la présence bilatérale d'ondes lentes à 4-7 par secondes avec amplitude maxima à la région antérieure et/ou à la région temporale, et sont le plus souvent rencontrées chez les personnalités psychopathiques agressives.

Les théories étiologiques psychologiques ou d'environnement se divisent en trois groupes. Dans le premier groupe se rangent les tenants de la théorie de l'"acting out" qui stipule que l'anxiété produite par des tendances instinctuelles défendues et non résolues est libérée par l'utilisation du mécanisme de défense qui permet l'expression de sentiments d'agression et par l'obtention de gratifications par les mécanismes de substitution et de déplacement. Le second groupe se rapport à la privation maternelle dans les premières années de la vie et la considère comme le principal facteur dans l'étiologie de la personnalité psychopathique. Les résultats de cette privation précoce et sévère sont la formation d'un concept pauvrement établi de l'"ego" et l'absence de développement de "superego". D'où le développement d'une agnosie sociale ou l'incapacité d'intégrer les concepts et les problèmes sociaux. Une indulgence excessive peut produire les mêmes résultats que la privation. Le troisième groupe se situe entre ces deux opinions et dénonce l'atmosphère familiale dans l'histoire du développement d'une personnalité psychopathique.

Il semblerait que la position la plus raisonnable à l'heure actuelle est de considérer dans la production de la personnalité psychopathique, l'interaction de facteurs héréditaires et d'un milieu déficient, comme par exemple la privation de la mère à la période infantile.

Il est parfois difficile de différencier une personnalité psychopathique des autres conditions psychiatriques. Tous les symptômes mis au compte de la personnalité psychopathique, peuvent être rencontrés dans d'autres maladies; aucun symptôme n'est pathognomonique de cette maladie excepté peut-être l'absence de conscience ou de superego. De plus, il y a plusieurs degrés de personnalité psychopathique.

Les tests psychologiques que l'on emploie de routine actuellement, ne semblent tout au plus qu'orienter vers ce diagnostic.

Cette maladie est la plus résistante à toutes les formes de traitement. A cause de sa difficulté à s'identifier et à ressentir de l'"empathie", le malade est incapable de transférence et rend la psychothérapie difficile. La littérature rapporte peu de cas chez qui l'on a employé les traitements physiques, cependant quelques cas très agressifs auraient bénéficié de la lobotomie trans-orbitaire.

Le pronostic est généralement considéré réservé, excepté pour quelques auteurs, dû au fait que l'individu atteint de cette maladie ne veut pas de traitement à moins d'être en difficulté avec la loi, montre très peu d'autocritique, manque de persévérance et est incapable d'identification et d'"empathie".

A l'heure actuelle, comme les résultats thérapeutiques sont pauvres, la seule approche demeure la prévention. Tous les efforts devraient être faits pour prévenir la privation maternelle, pour améliorer les conditions sociales, pour favoriser des recherches mieux organisées et plus étendues et pour dépister cette maladie aussitôt que possible. On devrait aussi s'employer à certifier ces individus dans des institutions psychiatriques appropriées.

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